

**PREA AUDIT REPORT INTERIM FINAL
JUVENILE FACILITIES**

Date of Report: July 19, 2017

Auditor Information			
Auditor name: Glen E. McKenzie, Jr., M.S.H.P.			
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Email: GlenEMcKenzieJr.LLC@austin.rr.com for PREA Audit Purposes Only			
Telephone number: 512-576-1800			
Date of facility visit: July 11-12, 2017			
Facility Information			
Facility name: Brazos County R. J. Holmgreen Juvenile Justice Center			
Facility physical address: 1904 Hwy 21 West, Bryan, Texas 77803			
Facility mailing address: (if different from above)			
Facility telephone number:			
The facility is:	<input type="checkbox"/> Federal	<input type="checkbox"/> State	<input checked="" type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input type="checkbox"/> Private not for profit		
Facility type:	<input type="checkbox"/> Correctional	<input checked="" type="checkbox"/> Detention	<input type="checkbox"/> Other
Name of facility's Chief Executive Officer: Doug Vance, Ph.D.			
Number of staff assigned to the facility in the last 12 months: 89			
Designed facility capacity: 48			
Current population of facility: 36			
Facility security levels/resident custody levels: secure pre-adjudication detention			
Age range of the population: 10-17			
Name of PREA Compliance Manager: Raymond Desir		Title: PREA Manager/Operations Manager	
Email address: rdesir@brazoscountytexas.gov		Telephone number: 979-361-1875	
Agency Information			
Name of Facility: Brazos County Juvenile Services Department			
Governing authority or parent facility: (if applicable) Brazos County Juvenile Board			
Physical address: 1904 Hwy 21 West, Bryan, Texas 77803			
Mailing address: (if different from above)			
Telephone number: 512-943-3303			
Facility Chief Executive Officer			
Name: Doug Vance, Ph.D.		Title: Executive Director	
Email address: dvance@brazoscountytexas.gov		Telephone number: 979-361-1802	
Facility-Wide PREA Coordinator			
Name: Sandra Calzada		Title: PREA Coordinator/Quality Assurance	
Email address: scalzada@brazoscountytexas.gov		Telephone number: 979-361-1847	

AUDIT FINDINGS

NARRATIVE

Overview

The Prison Rape Elimination Act (PREA) on-site audit of the Brazos County R. J. Holmgreen Juvenile Justice Center in Bryan, Texas was conducted on July 11-12, 2017 by Glen E. McKenzie, Jr., M.S.H.P. from Cedar Park, Texas, and a U.S. Department of Justice Certified PREA Auditor for Adult and Juvenile facilities. On the first day 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 the second day of the audit, the Auditor spent the balance of the on-site audit interviewing additional specialized staff, random and specialized residents, completed all interviews, reviewed selected staff and resident files and additional documents. Following completion of the on-site visit on July 12, 2017, the Auditor conducted an exit conference with the facility administration and staff to discuss preliminary findings and the subsequent audit processes and timeframes. The Auditor's comments were positively received during the audit by all the facility staff and administrators. Residents and staff were readily accessible at all times to the Auditor for the conduct of formal interviews. The facility administrators provided unimpeded access to all parts of the facility to the Auditor at all times and provided ample office space during the on-site audit. The Executive Director and facility staff demonstrated that PREA compliance is a priority as demonstrated by the quality of preparation of the Pre-Audit Questionnaire (PAQ) and organization of information provided to the Auditor.

Pre-Audit Phase

On May 16, 2017, the Auditor sent the facility the PREA Audit Notices to be posted in the facility. On May 23, 2017, the Auditor received electronic photographic evidence which was date-stamped to demonstrate that proper posting of these notices had been placed in the resident housing units, the main entrance of the facility, other areas of the facility and in the administration area of the facility. The audit notice had also been posted on the facility's website. As of the audit report date, the Auditor had not received any confidential correspondence via postal service mail or during the on-site audit.

The Brazos County R. J. Holmgreen Juvenile Justice Center staffs were requested to complete the Pre-Audit Questionnaire (PAQ) which was provided on May 31, 2017. The facility provided the completed PAQ to the Auditor along with supporting documents electronically and in a 3-ring binder on June 6, 2017 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 facility 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 few questions which were submitted to the PREA Compliance Coordinator on June 19, 2017 which responses were requested. Answers to the questions were submitted by the PREA Coordinator prior the on-site portion of the audit and reviewed by the Auditor prior to the on-site review. On the afternoon of July 10, 2017, the Auditor met with the facility PREA Compliance Coordinator to resolve any remaining issues.

On May 24, 2017, the Auditor requested the facility to compile a listing 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, LGBTI residents, etc.). The listings were provided to the Auditor on the afternoon of July 10, 2017 from which he selected the staff and residents (i.e., administration, specialized and random staff and specialized and residents still in the facility, etc.) to be interviewed. The Auditor also selected specific files (e.g., new hires, employees promoted, employees disciplined, residents disciplined, investigations, training records, etc.) to be reviewed during the on-site audit. On the first day of

the audit, the facility provided the Auditor with an updated listing of all residents in all housing units from which the Auditor made the final selection of random residents to be interviewed that represented all housing units.

On-Site Audit Phase

On the morning of July-11, 2017 the Auditor arrived at the facility at 8:15 a.m. and was shown to a large conference room in the administration wing of the building which would function as working base during the audit. The Auditor began by conducting an entrance conference with facility administration at 8:30 a.m. After introductions and welcoming remarks were made by the Agency Executive Director (Chief Probation Officer) and Assistant Agency Director, the Auditor discussed the audit schedule and an overview of the audit processes. Following the entrance conference, the auditor was escorted into detention facility for purposes of conducting an on-sight tour of the facility. During the tour the auditor observed camera placements to identify potential blind spots, observed staff placement and resident supervision, observed zero tolerance posters, PREA audit notice postings, reviewed the video monitoring system in the control room area, confidential resident files, unit logs, grievance forms, locked grievance boxes and hotline phone numbers posted in each living unit. The Auditor was provided unimpeded access to all parts of the facility, all secure rooms and storage areas in the facility. During the tour the auditor informally interviewed staffs and residents regarding sexual safety and facility policies and procedures. Following the facility tour, the auditor was led back into the conference room to discuss observations with facility administrators and staff. Additional questions were answered by executive and upper-level management staff. During the remaining duration of the on-site audit, the Auditor conducted staff, contractor and volunteer interviews in the conference room and interviewed residents in a private visitation room within the detention center.

Site Review

On the first day of the audit after the entrance conference, the Auditor toured the physical plant escorted by Ms. Sandra Calzada, PREA Coordinator/Quality Assurance, the Facility Administrator and the facility Operations Manager/PREA Compliance Manager. The Auditor spoke informally with staff and residents during the tour which covered all housing and common areas of the facility, day areas, programming areas, and shower and toilet areas. The Auditor noted video camera placements throughout the facility and reviewed the video monitoring setup in the control room areas. The auditor was informed of the location of video camera strategically added since the last PREA audit. The auditor observed Notices of the PREA Audit posted throughout the facility as required.

During the on-site review of the physical plant, the Auditor observed, among other things, the facility configuration, staff supervision of residents, dorm layout including individual wet sleeping rooms, shower/toilet areas, placement of PREA posters and PREA informational resources, security monitoring, resident movement procedures, resident programming and resident interaction with staff. The tour concluded after approximately 1.5 hours.

Resident populations on the first day of the audit were as followed:

- Alpha (12 rooms); (8 residents) - female
- Bravo (10 rooms); (7 residents) - male
- Charlie (10 rooms); (vacant)
- Delta (12 rooms); (12 residents) - male

Interviews

Formal private interviews were conducted with facility, staff, residents, volunteers and contractors. Eighteen total facility staff members were interviewed during the on-site review which included administrative staff, random staff and specialized staff. The auditor interviewed ten (10) random staff and eight (8) specialized staff performing eleven (11) functions. Interviews included ten (10) random staff representing all shifts in the

programs. The facility shifts are:

- Shift 1: 6 :00 A.M. - 2:00 P.M.;
- Shift 2: 2 :00 P.M. -10:00 P.M.; and
- Shift 3: 1 0 :00P.M. - 6:00 A.M.

During the on-site audit, the auditor interviewed the following staffs: agency Executive Director, facility Director, PREA Compliance Coordinator, PREA Compliance Manager/Operations Manager, intermediate/higher-level facility staff who conduct unannounced visits to the facility during the all shifts, medical and mental health staff, human resources staff (agency Executive Director), incident review team staff, staff members who monitor for retaliation, staff who performs screening for risk of victimization and abusiveness, the staff responsible for monitoring for retaliation, first responders, intake staff, security staff and ten (10) random correctional officers. There was no volunteers or contractors interviewed as none were at the facility or available during the audit. All were interviewed using the DOJ protocols that question their PREA training and overall knowledge of the facility'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 also interviewed the contracted SANE administrator and the Executive Director of the Brazos County Rape Crisis Center, Inc. The Auditor also communicated via electronic communication with representative of the Brazos County Sheriff's Department who provide for the conduct of criminal investigations.

The resident population ranged from 22 residents in July 2016 to 34 residents in June 2017. In the previous 12 months, a total of 728 residents had been admitted to the facility. The age range of resident population is 10 years to 17 years of age. No resident had requested to speak with the auditor nor had the auditor received any written correspondence from any resident or staff. In the prior 12 months, there had been zero (0) allegations of sexual abuse and there had been zero (0) allegations the facility received that a resident was abused while confined at another facility.

On the first day of the on-site review, there were 27 residents (i.e., 19 males and 8 females) housed in the facility in three (3) housing units. A fourth housing unit was vacant. The Auditor interviewed ten (10) residents selected randomly from the three (3) occupied housing units representing approximately 37% of the resident population. There were no residents who had reported a sexual abuse incident, no residents who were disabled and limited English proficient, no transgendered, intersex, gay, lesbian or bisexual, no residents in isolation and no residents who disclosed prior victimization during risk screening. Both male and female residents were interviewed (i.e., 7 males and 3 females). Residents were interviewed using the 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. There were no residents who reported a sexual abuse, no residents who were disabled and limited English proficient, and no residents who identified as transgender, intersex, gay, lesbian or bisexual. There were no residents who had disclosed prior sexual victimization during risk screening and there were no residents placed in isolation for the purposes of separating residents who identified as transgender, intersex, gay, lesbian or bisexual.

The auditor reviewed the Memorandum of Understanding (MOU) between the facility and St. Joseph's Hospital to provide SANE and SAFE services and the agreement between the Brazos County Juvenile Board and the Brazos Valley Sexual Assault Resource Center to provide a 24- hour hotline for reporting sexual abuse and sexual harassment as well as counseling services for victims and victim support. The auditor spoke with the St. Joseph's Hospital administrator to confirm the MOU and SANE/SAFE services to be provided as required. Directors from the agencies stated that their agencies had agreed to provide relevant services. All allegations of sexual abuse or sexual harassment are to be reported to the Brazos County Sheriff's Office which had agreed through a Memorandum of Understanding to conduct criminal investigations. The auditor spoke with the Brazos County Sheriff's Office representative who confirmed that criminal investigative services would be provided to the detention center as needed. The agency Executive Director and the Sheriff's Office representative confirmed the accuracy with statements contained in the PAQ that since the last PREA audit,

zero (0) criminal investigations of allegations of sexual abuse had been conducted. Administrative investigations are to be conducted by multiple trained staff at the facility. The auditor also contacted the toll free hot-line (TJJD) and spoke with an operator who explained their office accepted sexual abuse allegations at any time.

The Brazos County Juvenile Detention Center's mission is stated as "To provide outstanding quality in service and programming that keep the citizens of Brazos County safe from juvenile crime, that promote victim restoration, and that encourages, assists, and enables our juveniles to consistently engage in pro-social, non-criminal behaviors."

File Review.

The Auditor requested the facility to provide a listing of personnel and resident files for possible review. From those listings, the Auditor selected a random sample of files to review and notified the facility. All files were provided to the Auditor in the main conference room where the Auditor was based. Prior to the on-site audit, the PREA Coordinator provided the Auditor with a listing of staff by hire date which cited dates for criminal records and child abuse registry checks and documentation of check with prior institutional employers. In order to verify compliance, the auditor selected at random three (3) employee personnel files which were reviewed applicable to hiring and training. Two (2) files for volunteers and contractors were reviewed. Prior to the on-site audit, the PREA Coordinator also provided the Auditor with a listing of residents by admission date, screening date and orientation/comprehensive education dates. Case files for four (4) youth in the facility were reviewed to evaluate screening and intake procedures, resident education and other general programmatic areas.

Exit Conference.

The Auditor conducted an exit conference with the Facility officials on the afternoon of Wednesday, July 11, 2017. Facility administration and staff were very open and receptive to discussion of any area where PREA compliance possibly could continue to be improved.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Brazos County Juvenile Detention Center is located in Bryan, Texas. Bryan is a city in Brazos County, Texas, United States. As of the 2010 census, the city had a population of 76,201. It is the county seat of Brazos County and is located in the heart of the Brazos County Valley (southeast Central Texas). It borders the city of College Station, which lies to its south. Together they are referred to as the Bryan-College Station metropolitan area, the sixteenth largest metropolitan area in Texas, containing around 190,000 residents.

The R. J. Holmgreen Juvenile Justice Center operates the pre-adjudication, secure detention center. The facility is located at the Brazos County Juvenile Services Department headquarters at 1904 West S.H. 21, Bryan, Texas, 77803, adjacent to the Brazos County Sheriff's Department. The detention center is a secure environment for youth charged with an offense and pending a court hearing. It is designed to provide a safe living environment and a full range of services for the juvenile to include: medical, educational, nutritional, psychological and recreational services.

The facility is equipped and staffed to meet the residents' basic needs, including academic instruction, which is operated by the Bryan Independent School District.

The R. J. Holmgreen Juvenile Justice Center is a co-ed facility certified by the Texas Juvenile Justice Department (TJJD) to house up to 48 youth ages 10 to 17, who have been arrested by a law enforcement facility and charged with a criminal offense, and juveniles alleged to have violated their conditions of probation and are waiting Juvenile Court processing. The average length of stay is approximately 18 days. The facility physical plant

includes 44 single-occupancy wet rooms and four wet isolation rooms available for youth requiring room confinement due to behavioral or medical concerns. The four isolation beds are used for regular occupancy as needed. The facility has 4 PODS of single occupancy housing: Alpha (12 rooms), Bravo (10 rooms), Charlie (10 rooms), and Delta (12 rooms).

The fundamental goal of the program “is to provide a safe and secure environment for residents and staff, while the staff gathers valuable information regarding the child’s family, school, social, medical, and psychological histories, to aid the Probation Services Division in the disposition of the case. In addition, the center provides rehabilitative programming designed to improve the self-esteem of residents and reduce their chance of recidivism.”

It should be noted that facility staff were very familiar with the residents; knew their individual names, their background, treatment needs, characteristics and their involvement with families. Staff was observed speaking politely and in a professional manner with residents. There was many staff that had numerous years of service at the facility. Staff spoke highly of the facility managers, of other employees and the numerous programs offered to residents. All residents stated they felt very safe at the facility and could speak with any staff about any issues and/or concerns.

The R.J Holmgreen Juvenile Justice Center has 95 video cameras currently operational, in use inside the facility as well as on the exterior of the facility. Video cameras are placed in corridors, housing units, program areas, visitation areas and exterior recreational areas. There are no cameras in individual resident rooms or in the shower or toilet areas. The Education wing is equipped with video cameras covering the hallways and a camera in each classroom. All cameras are continuously monitored by staff in the secure control room.

The facility is well maintained, in good repair and exceptionally clean. Housing units are well equipped and provide residents with a comfortable environment. Dorms are painted soft colors to enhance the housing units and reduce the institutional feel. 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 residents and residents appear to follow the direction of staff which contributes to a calm environment conducive to rehabilitation.

The facility is certified by the local 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. Of note are the current TJJD 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 detention facility offers a variety of programming and services for residents. The facility has health services provided by a Licensed Vocational Nurse and through a contract physician that comes to the facility according to schedule and as needed. A Nurse Practitioner manages the psychotropic medication for residents at the facility. The facility has a strong community volunteer program consisting of 88 volunteers who serve the facility residents.

SUMMARY OF AUDIT FINDINGS

During the past 12 months, the Brazos County Juvenile Justice Center reported zero (0) allegations of sexual abuse or sexual harassment that occurred in the facility in their responses to the PAQ and was verified through interviews and record reviews. No criminal or administrative investigations were conducted since the prior PREA audit.

The facility has a strong zero tolerance policy in place and comprehensive PREA policies covering all the requirements of the PREA standards. The facility has an overarching Central Administration set of policies approved by the Executive Director for PREA compliance issues.

Overall, interviews with residents reflected that they are aware of and understand the PREA protections and the facility's zero tolerance policy. Residents stated they received written materials at intake (e.g., Resident Handbooks, etc.) that provided detailed information about PREA protections, the multiple ways to report sexual abuse or harassment and ways to protect them from abuse. Subsequent to intake, residents are provided more comprehensive education on PREA that includes personal instruction in addition to being required to watch a comprehensive PREA educational video. Posters related to reporting sexual abuse and sexual harassment are placed in dayrooms of the facility and in housing units. Residents indicated they understood the various ways to report abuse internally and externally.

Residents stated to the Auditor how they would properly report any incident of sexual abuse and knew to whom they should report if they experienced or had knowledge of another resident who had experienced sexual abuse. Residents expressed to the Auditor that they trust staff and could report sexual abuse to almost any staff in the facility. The Auditor's observation of staffs' interactions with residents was positive and appropriate. Residents consistently indicated to the Auditor that they felt safe in the facility.

All facility staff interviewed stated they had received detailed training in PREA policies and procedures and could accurately describe the meaning of the facility's zero tolerance policy. Staffs were knowledgeable of their roles and responsibilities in the prevention, detection, reporting and response to sexual abuse, sexual harassment or retaliation. Staffs were able to describe the variety of reporting mechanisms for residents, staff, contractors and volunteers to report sexual abuse, sexual harassment or retaliation. Staffs demonstrated they were well trained on the PREA first responder's protocol for any PREA related allegation and they could describe clearly the appropriate steps they would follow if they were a first responder to such incidents. The PREA Compliance Coordinator/Quality Assurance staff, PREA Compliance Manager/Operations Manager and other staff stated that on-going periodic training was conducted to reinforce the importance of maintaining knowledge of all issues related to preventing, detecting, reporting and responding to sexual abuse, sexual harassment and retaliation. Staff knew residents by name and treated the residents with a sense of care and concern. Many employees at the facility have a long tenure and expressed their dedication to their roles at the facility and their work with residents.

In summary, following the review all pertinent information, observations from the on-site review, interviews with residents and staffs, the Auditor determined that the facility leadership and staff made PREA compliance a high priority. It was evident that a significant amount of time and resources had been devoted to policy and procedure development, staff training and residents' orientation/education on all aspects of PREA. The Auditor reviewed the PREA training material/curriculum and noted that the PREA Compliance Coordinator and facility staffs have done well in the utilization the training resources of the PREA Resource Center website as well as other county, state and national information and training resources. The high level of pre-audit preparations, organization of audit files and other documentation reviewed submitted in the PAQ to the Auditor facilitated the conduct of the PREA audit.

The facility has a strong PREA policy (written around the PREA standards) which reinforced the facility's commitment to ensuring the sexual safety of residents and staff in the facility. It was evident that staff and residents were committed to the awareness of sexual safety standards 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 as observed by this Auditor. The Auditor noted the overwhelmingly positive attitude from facility administration and PREA compliance team toward any Auditor input on any suggestions for possible improvement.

PREA Standards Compliance Overview – Final Audit Report

The R. J. Holmgreen Brazos County Juvenile Justice 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. As a point of information, references to the facility PREA policy was effective on 12/10/2015 and contain minor revisions dated 5/31/2017.

PREA Standards Compliance Overview – Final Audit Report

Number of standards exceeded: 0

Number of standards met: 41

- §115.311; 115.312; §115.313; §115.315; §115.316; §115.317; §115.318; and
- §115.321; §115.322; and
- §115.331; 115.332; §115.333; §115.334; §115.335; and
- §115.341; §115.342 and
- §115.351; §115.352; §115.353; §115.354; and
- §115.361; §115.362; §115.363; §115.364; §115.365; 115.366; §115.367; §115.368; and
- §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: 0

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. Facility PREA Policy 115.311 Zero Tolerance of Sexual Abuse and Sexual Harassment; PREA Coordinator

[Pages 1-3]

2. Youth Admission Pamphlet (English and Spanish) – “Youth Safety Guide for Juvenile Services”
3. Resident Detention Handbook (English and Spanish) “A RESIDENT’S GUIDE TO SUCCESS IN THE BRAZOS COUNTY JUVENILE DETENTION CENTER”
4. Facility PREA Video
5. Facility Organization Chart identifying PREA Coordinator
6. Facility PREA Policy in its entirety includes mandatory reporting, zero tolerance toward all forms of sexual abuse and sexual harassment and outlines the facility’s approach to prevention, detecting and responding to such conduct. As a point of information, the Facility PREA policy is segmented into each specific PREA standard; i.e., 115.311, 115.312, 115.313, etc.

Findings (By Subsection):

Subsection (a): The R. J. Holmgreen Juvenile Justice Center has a comprehensive policy on sexual abuse and sexual harassment contained in PREA Prevention Planning. The policy clearly mandates zero tolerance toward all forms of sexual abuse and sexual harassment. The policy is detailed and well written. The policy contains definitions that are compliant and consistent with the PREA definitions in the PREA Definitions section. The policy further outlines the Facility’s approach to preventing, detecting, and responding to sexual abuse and sexual harassment.

Subsection (b): Sandra Calzada is the designated facility wide PREA Coordinator and her official title is PREA Coordinator/Quality Assurance. She reports directly to the facility Assistant Director and has direct access to the agency Executive Director. The PREA Coordinator reports that she has sufficient time and authority to develop, implement and oversee facility efforts to comply with PREA. Ms. Calzada has done an exemplary job of overseeing the PREA compliance efforts of the facility.

Subsection (c): The R. J. Holmgreen Juvenile Justice Center also has a designated PREA Manager. The PREA Manager serves as Operations Manager of the facility. While the facility is not required to have a PREA Compliance Manager because it is a single facility, the agency chose to designate a PREA Compliance Manager. This decision has enhanced the facility’s PREA compliance efforts and exceeded the standard which further strengthens and ensures the sexual safety of residents and staff in the facility

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. Facility policy 115.312 Contracting with other entities for the confinement of residents. [Page 3]
2. Facility contracts with service agencies requiring compliance with the Prison Rape Elimination Act of 2003
3. Fiscal Year 2016 and Fiscal Year 2017 Residential Services Contracts

4. Interviews with the following:
 - a. PREA Coordinator
 - b. Facility's Contract Administrator

Findings (By Subsection):

Subsection (a): R. J. Holmgreen Juvenile Justice Center policy 115.312 Contracting With Other Entities For the Confinement of Residents provides all residential service contracts must include provisions that require the service provider to comply with PREA. The facility currently has no residential service provider contracts being utilized. All future residential service contracts are required by agency policy to contain the PREA language that requires compliance of the service provider with the PREA standards.

Subsection (b): The facility policy requires that residential contracts will provide that the facility will monitor the progress of their residential service providers at regular intervals. Interviews with the Executive Director/Chief Juvenile Probation Officer and the Assistant Chief Juvenile Probation Officer confirmed this requirement will be performed if residential contracts are needed in the future.

Corrective Action: None.

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)
- 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. Facility policy 115.313 Supervision and Monitoring [Page 3-4]
2. Schematic of number and placement of video cameras inside and outside the facility
3. Facility Staffing Plan – January 2017
4. Facility Program Schedule
5. Detention Master Staffing Schedules
6. FY 2016 Personnel Budget Requests for additional staff to meet PREA required staffing ratios.
7. Interviews with random staff and random residents
8. Interviews with the following:
 - a. Superintendent
 - b. PREA Compliance Manager
 - c. PREA Coordinator
 - d. Intermediate or Higher-Level Facility Staff

Findings (By Subsection):

Subsection (a): Facility policy requires the facility to develop staffing plans for its facility. The facility has a staffing plan which addresses the 11 required elements of this standard. The plans demonstrate the calculation of the staffing patterns required.

Subsection (b): Facility policy dictates that deviations are only allowed during limited and discrete exigent circumstances. There had been no deviations from the staffing plan documented on the PAQ. The agency has developed a form to document such deviations should that be necessary.

Subsection (c): The tour reflected compliance with all components; however while the current staffing ratios are less than 1:8 and 1:16, facility policy dictates that those ratios will be met no later than October 1, 2017. The facility currently complies with the TJJJ present staffing ratio requirements. This facility policy regarding the PREA staffing ratio which is not required to be implemented until October 1, 2017 identifies correctly the staffing requirements of the PREA standard effective October 1, 2017. Due to the reduced resident population within the facility, the staff ratios during the audit reflected the 1:8 during resident waking hours and 1:16 during resident sleeping hours. An additional staffing budget request had been submitted to the County Judge on May 26, 2016 and subsequently approved to phase in the seven (7) additional Juvenile Correctional Officers required to bring the facility into compliance with the PREA mandated staffing supervision ratio no later than October 1, 2017. Only security staff counts toward these ratios. Deviations are only allowed during limited and discrete exigent circumstances. This subsection regarding the new juvenile staffing ratios is not applicable until October 1, 2017.

Subsection (d): Facility policy requires the annual review of the staffing plan. The facility staffing plan was officially reviewed in May 2017. In discussions with the PREA Coordinator, she indicated the facility plans to perform a subsequent annual review of the staffing plan prior to October 1, 2017 confirm and to document the PREA mandated staffing ratio.

Subsection (e): Facility policy requires intermediate and higher level supervisory personnel in each program to conduct and document unannounced rounds at least once per shift each month. Documentation of the unannounced visits by intermediate and higher-level supervisors is documented on the "PREA Unannounced Round Form". The PREA Unannounced Round Form is submitted to the Quality Assurance staff person and other higher level Facility management for review. A random review PREA Unannounced Round Forms documented unannounced visits on all shifts monthly as required. Interviews with intermediate or higher-level staff confirmed the random reviews were conducted.

Corrective Action: None

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. Facility policy 115.315 Limits to cross-gender viewing and searches [Page 5]
2. Facility form Cross-Gender Strip Search and/or Cavity Search
3. Facility training curriculum – “Guidance in Cross-Gender and Transgender Pat Searches” (PREA Resource Center training document)
4. Facility training acknowledgement form documenting training of detention center staff on Cross-Gender and Transgender Pat Searches

Interviews with the following:

- a. random residents
- b. random staff

Findings (By Subsection):

Subsection (a): Facility policy prohibits cross-gender strip or pat searches, only in exigent circumstances or when performed by LVN/Physician/Physician’s Assistant; allowing residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing, requiring opposite gender announcements, justification and documentation requirements for all cross-gender strip searches, cross-gender visual body cavity searches, and cross gender pat-down searches.

Subsection (b): Facility policy prohibits cross-gender strip or pat searches, except in exigent circumstances. There have been no cross-gender pat searches as documented in the PAQ and verified through interviews with residents and staff.

Subsection (c): Facility policy requires all authorized searches to be justified and documented.

Subsection (d): Facility policy requires that all residents are able to shower, perform bodily functions, and change clothing without nonmedical staff viewing their genitals, buttocks, breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routing cell checks (including viewing via video camera and recordings). Unless there is an exigent circumstance staff of the opposite gender entering a unit will announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing. Staff will document on the unit log if an exigent circumstance occurred. The Auditor noted that during the tour of the facility physical plant, the PREA Coordinator and other staff made opposite gender announcements appropriately upon entering each of the housing units. Compliance was further confirmed through random staff and random resident interviews.

Subsection (e): Facility policy requires clearly that staff shall not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident’s genital status. If the resident’s genital status is unknown, it may be determined during conversation with the resident, by reviewing medical records, or, if necessary by learning that information as a part of a broader medical exam conducted in private by a medical practitioner. This policy prohibits the search of a transgender or intersex resident for the sole purpose of determining the resident’s genital status. Interviews with random staff corroborated that no such searches had been conducted at the facility. There were no identified transgender or intersex residents in the facility during the on-site audit.

Subsection (f): Facility policy requires that all security staff shall be trained how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. The auditor confirmed that the facility had trained all staff on how to conduct pat-down searches of transgender and intersex residents in a professional and respectful manner and in the least intrusive manner possible. Training documentation was submitted to evidence this and interviews with staff indicate they could articulate proper search procedures for pat-down searches which are the only searches they are allowed to conduct.

Corrective Action: None

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. Facility policy 115.316 [Pages 5-6]
2. Resident Pamphlet – “End The Silence”
3. Training Curriculum/training logs related to disabled residents and residents with limited English proficiency
4. Language Line Services, Inc. Memorandum of Understanding, May 2014
5. Interview – Facility Administrator
6. Interviews – disabled/limited English proficient residents and random staff

Findings (By Subsection):

Subsection (a): The facility has established procedures to provide disabled residents equal opportunity to participate in and benefit from all aspects of the facility’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The facility utilizes Language Line Services, Inc. and Communication by Hand, LLC for their translation needs. PREA posters are posted throughout the facility in Spanish as well as English. Resident handbooks containing information of this service are available in both English and Spanish.

Subsection (b): The facility has established policies and procedures to provide residents with limited English proficiency equal opportunity to participate in and benefit from all aspects of the facility’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The facility has multiple staff members who speak Spanish and can assist with translation when necessary. External translation services are available through contracted services when needed.

Subsection (c): The facility policy prohibits relying on resident interpreters, resident readers, or other types of resident assistant except in limited circumstances as required by this subsection. Interviews with staff corroborate this policy is the practice in the facility. There were no residents with disabilities or who were of limited English proficiency at the facility during the on-site audit.

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. Facility policy 115.317 [Page 17-18] Hiring and promotion
2. Completed Pre-Audit Questionnaire (PAQ)
3. Criminal History, Child Abuse Registry, and Prior Institutional Checks Spreadsheet (Employees and Contractors)
4. Reference Check Form PREA
5. Personnel files for current employees, new employees and employees receiving promotions
6. Volunteer/Contractor files
7. Interviews with the following:
 - a. Agency Executive Director,
 - b. Facility Director,
 - c. Human Resources staff (Agency Executive Director) and
 - d. PREA Compliance Coordinator

Findings (By Subsection):

Subsection (a): The R.J. Holmgreen Juvenile Justice Center has not hired, promoted anyone or enlisted contractor service providers who may have contact with residents who have engaged in any of the PREA standards prohibited criteria related to sexual abuse or sexual harassment. The facility policy regarding hiring and promotions is compliant with this standard. The facility utilizes the State of Texas Department of Public Safety fingerprint system (FAST) to perform new employee, contractor, volunteer, intern background checks as well as for anyone who may have contact with residents. The PREA Coordinator compiled a Criminal History, Child Abuse Registry, and Prior Institutional Checks Spreadsheet of employees and contractors presented to the Auditor which demonstrated compliance with this standard subsection. The Auditor reviewed a sample of three (3) employee and two (2) contractor files and determined the facility is compliant with this standard subsection.

Subsection (b): The facility policy considers any incidents of sexual harassment in determining whether to hire or promote anyone or to enlist the services of any contractor who may have contact with residents. The hiring practice requires prospective employees to answer and/or disclose PREA related conduct about all the PREA conduct detailed in this standard.

Subsection (c): The facility policy requires that a criminal background check and child abuse registry check be conducted for all new employees prior to hiring. The facility utilizes the State of Texas Department of Public Safety fingerprint system (FAST) to accomplish that requirement. The Auditor reviewed an informational spreadsheet which tracks the checks and reviewed three (3) personnel files to corroborate that these checks had been done as required by policy. The facility requires prospective employees to disclose any prior institutional employers and all places the applicant has resided for the past 10 years. Interviews with Human Resources staff corroborate this practice.

Subsection (d): The facility policy requires that a criminal background check and child abuse registry check be conducted for all contractors prior to their utilization. The Auditor reviewed an informational spreadsheet which tracks the background checks corroborated that these checks had been done as required by policy. The PAQ submitted by the facility reports that in the past 12 months, 13 persons were hired who may have contact with residents who had criminal background checks performed. Additionally, 1 contract for services in the past 12 months had criminal background check done. Interviews with Human Resources staff corroborate this

practice. The facility has a variety of contractors that provide services to the residents. Many of these contractors have professional licenses and criminal history checks are conducted by the licensing entity. Counselors are licensed by the Texas Department of State Health Services (TDSHS) and a criminal history check is done at the initial application for licensure, and during renewals every two years as specified in Texas Administrative Code, Title 22, Part 30, Section 681.121(a); TDSHS also conducts a random check process periodically. Additionally, the licensee is required to report any changes to criminal history as they occur. The Psychologists and Nurse Practitioner who work at the facility are licensed by The Texas State Board of Examiners of Psychologists. Texas Administrative Code, Title 22, Part 24, Section 463.7(b), states that the board will obtain updated criminal information from the Texas Department of Public Safety quarterly. The facility verifies that all professionally licensed staff is in good standing with their licensing entity.

Subsection (e): Facility policy requires criminal background checks to be done every 2 years for current employees and contractors. This practice exceeds this section of the standard. The Auditor reviewed three (3) random personnel files of current staff and confirmed that the checks had been completed.

Subsection (f): Facility policy requires the facility to ask all applicants and employees who may have contact with residents about the PREA related misconduct in this section in written applications or interviews for hiring or promotions and as part of employees' evaluation processes. Policy also requires the facility to impose upon employees a continuing affirmative duty to disclose any such misconduct and to report such conduct immediately (within 24 hours).

Subsection (g): Facility policy states that material omissions regarding PREA-related conduct, or the provision of materially false information is grounds for termination.

Subsection (h): Facility policy requires the Executive Director or designee to provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work. Interviews with Human Resources staff confirmed this practice.

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)
- 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. Pre-Audit Questionnaire (PAQ)
 - a. Facility policy – Upgrades to Facilities and Technology Policy 318
2. Interviews with the following:
 - a. Facility Head
 - b. Superintendent

Findings (By Subsection):

Subsection (a): The facility has not acquired a new facility or made a substantial expansion or modification to the existing facility since the last PREA audit.

Subsection (b): The facility has installed an additional 12 of the 15 video cameras approved since August 20, 2016. The remaining cameras are being installed.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy 115.321 Evidence Protocol and forensic medical examinations [Page 8]
3. Written memorandum from Brazos County Sheriff's Office
4. Written agreement with Brazos County Rape Crisis Center, Inc. (SARC)
5. Memorandum of Agreement between the St. Joseph's Hospital and the Brazos County Juvenile Services Department.
6. Review of detention staff professional counselor licenses who may assist victims if requested
7. Interviews with the following:
 - a. Random Staff
 - b. PREA Compliance Manager
 - c. Residents who Reported a Sexual Abuse
 - d. Telephone interview with Brazos County Sheriff's Office Representative
 - e. Telephone interview with Administrative Director Emergency Services, St. Joseph Hospital providing SAFE/SANE services
 - f. Telephone interview with Executive Director, Sexual Assault Resource Center (SARC)

Findings (By Subsection):

Subsection (a): The R. J. Holmgreen facility is responsible for the conduct of administrative investigations into allegations of sexual abuse. Criminal investigations are conducted by the Brazos County Sheriff's Office. The facility follows a uniform evidence protocol (first responder protocol) that maximizes the potential for obtaining usable physical evidence for administrative investigations. Facility staff has been trained in a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence. Interviews with random staff and the PREA Compliance Coordinator confirmed they utilize the protocol that maximizes the potential for obtaining usable physical evidence. The PREA Coordinator stated that the protocol is based on the U.S. Department of Justice's Office on Violence Against Women publication which was confirmed by

the Auditor. The Brazos County Sheriff's Office agreed through a MOU with facility they will conduct all criminal investigations. The auditor communicated with the Brazos County Sheriff's Office via email who confirmed the agreement remained in place as well as confirmed the proper protocol to be utilized should a criminal investigation be necessary. Staff has been provided first responder card that contain the first responder protocol; these cards can be carried in the staff member's wallet or ID badge to help refresh memory if and when an acute incident occurs in the facility. Staff interviews demonstrated knowledge of the first responder's evidence protocol in the facility.

Subsection (b): The facility investigative staff have been trained to conduct investigations based on the U.S. Department of Justice's Office on Violence Against Women publication protocol, it was recommended that the facility policy explicitly state that the facility follows the national protocol as stated in this standard as it relates to evidence preservation at the scene and how to treat a victim of sexual abuse specifically.

Subsection (c): A written agreement completed with the St. Joseph Hospital and the Brazos County Juvenile Services Department provides for forensic medical examinations offered to residents without financial cost to the residents. A telephone interview with Administrative Director Emergency Services, St. Joseph Hospital stated that the written agreement will provide forensic medical examinations. The Administrative Director explained that these services are available 24 hours per day and seven (7) days per week. Victim advocates are available through the Brazos County SARC which provides rape crisis hotlines and counseling services for victims and victim support. There are qualified staff members at the facility who can provide crisis intervention and accompany/support the resident through the forensic medical examination processes/interviews, emotional support, crisis intervention, information and referrals, if requested by the resident. Interview with the Administrative Director confirmed that there had been no forensic medical exams conducted with residents at the facility.

Subsection (d) and (e): The facility has an agreement in place with St. Joseph Regional Hospital and the Brazos County Rape Crisis Center (Sexual Assault Resource Center) provide victim advocacy services to residents that are victims of sexual abuse. Interviews with the PREA Compliance Manager and Administrative Director Emergency Services-St. Joseph Hospital and the Brazos County Executive Director, SARC confirmed the MOU with the facility. There had been no residents who reported sexual abuse.

Subsection (f): The facility has requested the Brazos County Sheriff's Office to follow the requirements of this standard subsections (a) through (e). The Sheriff's Office detective indicated that they use a protocol entitled "Physical Evidence Handbook" developed by the Texas Department of Public Safety which is standards based on a nationally recognized protocol based on the Department of Justice Office on Violence against Women protocol or similarly comprehensive and authoritative protocol developed after 2011. The PREA Coordinator provided the Auditor with written correspondence to the Sheriff's Office asking that they use the protocol is based on the U.S. Department of justice's Office on Violence Against Women publication.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Facility policy 115.322 Policies to ensure referrals of allegations for investigations [Page 9]
3. Brazos County Juvenile Detention Center website link
<http://www.brazoscountytexas.gov/index.aspx?NID=515>
4. Interviews with Assistant Chief Juvenile Probation Officer, PREA Manager, facility investigator staffs and Brazos County Sheriff's Office Investigator
5. Interviews with the following:
 - a. Agency Head
 - b. Facility investigative staff

Findings (By Subsection):

Subsection (a): Facility policy ensures that administrative investigations are completed for all allegations of sexual abuse and sexual harassment. The PAQ documents that the facility reports zero (0) allegations since the last PREA audit.

Subsection (b) and (c): Facility policy ensures that an administrative and/or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. Criminal cases are referred to the Brazos County Sheriff's Office that has the legal authority and responsibility to investigate all incidents occurring in the facility. The facility publishes this policy on its website as documented by the Auditor. Interviews with facility investigative staff indicate this is the practice of the facility.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Facility policy Employee Training 115.331 [Page 9]
3. NIC PREA Training Curriculum: training provided by TJJD
4. Brazos County Juvenile Services Staff Training Acknowledgement Form
5. PREA Training Curriculum and Materials
6. Employee Personnel/Training Records
7. Interviews with the following:
 - a. Random Staff

Findings (By Subsection):

Subsection (a): Facility policy [Employee Training] requires all employees who may have contact with residents shall receive, during orientation, training on the 11 elements required by this subsection. The Auditor reviewed the training materials used to verify all topics were addressed. The Facility has a strong training for new employees on PREA policies, procedures and facility practices. The PREA Coordinator has done an excellent job on the Facility PREA training program utilizing comprehensive curriculum and trainings.

Subsection (b): The R.J. Holmgreen facility is a co-ed facility. All employees are trained to work with both male and female residents. Training is tailored to the gender of the residents and to the unique needs and attributes of residents of juvenile facilities.

Subsection (c): The facility requires initial training and frequent on-going refresher training required by this subsection. The facility reports in the PAQ that 145 staffs have been trained in PREA related issues. A PREA Training spreadsheet has been created which tracks all employees training that is received annually.

Subsection (d): A pre-post test is administered to ensure staffs understand the training they received. Following training, all employees are required to sign a statement that they understood the training provided. Documentation of such training and evidence of understanding are maintained in the employee's files. The Auditor reviewed a random sample of three (3) personnel training files to verify training for new staff as well as tenured staff.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Facility policy 115.332 Volunteer and Contractor Training [Page 10-11]
3. Staff Acknowledgement Form
4. Volunteer and Contractors training "PREA Overview, PREA Law, How it affects Your Job & Audit Process"
5. PREA Training Curriculum and Materials
6. Volunteer/Intern/Contractor Training Records

Findings (By Subsection):

Subsection (a): Facility policy requires all contractors and volunteers that have contact with residents are trained on their responsibilities under the facility's PREA policies and procedures regarding sexual abuse and sexual harassment prevention, detection and response. In the PAQ, the facility reports that all volunteers and contractors have been trained on PREA. A spreadsheet documenting that the required training had been provided was provided to the Auditor as evidence of training confirmation. There were no volunteers

or contractors at the facility during the audit.

Subsection (b): Facility policy provides that the level and type of training provided to volunteers and contractors is based on the services they provide and the level of contact they have with residents. All volunteers and contractors who have contact with residents had been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and how to report such incidents.

Subsection (c): Facility policy requires the facility to maintain documentation confirming that volunteers/contractors understand the training they have received. The Auditor noted that volunteers and contractors had been given pre/post-tests to further document their understanding of the training. The PREA Coordinator provided training documentation with signatures of volunteers and contractors acknowledging that they understand the training they received. The Auditor randomly selected two (2) volunteer training records and confirmed that the facility is in compliance with this standard. There were no volunteers or contractors at the facility during the audit.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Facility policy 115.333 Resident Education [Pages 11-12]
3. PREA Unit Orientation Form with resident signature
4. Resident Admission/Release/Intake Orientation/Comprehensive Education Spreadsheet
5. Zero Tolerance Pamphlet
6. Resident Education Materials
 - a. Residents Orientation Handbook
 - b. Safeguarding Your Sexual Safety (Video)
 - c. PREA posters and signage
7. Resident Files
8. Observation of signage and educational materials on display in facility housing units and programming areas during tour of physical plant
9. Interviews with the following:
 - d. Intake Staff
 - e. Random Residents

Findings (By Subsection):

Subsection (a): Facility policy requires that residents receive information at the time of intake about the zero-tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of

sexual abuse or sexual harassment. The facility utilizes a variety of resident acknowledgement forms to document and evidence the provision of this training to residents. The PAQ documents that in the past 12 months, 587 residents were provided PREA education at intake. The PREA Coordinator presented a spreadsheet which noted date of residents' admission and date of receipt of the required information demonstrating compliance.

Subsection (b): Facility policy requires that within 10 days of intake, the facility shall provide comprehensive age-appropriate PREA education to residents. The facility utilizes the Safeguarding Your Sexual Safety video that was developed by the Texas Juvenile Justice Department (TJJD). Residents view the video in either English or Spanish. The portions of the video pertaining to TJJD are skipped and the facilitator uses a modified instructor's guide to cover the material as it relates to Brazos County. The video is provided twice a week on Saturday and Sunday and all new residents get to review the videos and receive information led by an instructor. Three (3) resident files were reviewed randomly by the Auditor to verify the comprehensive education was occurring in a timely fashion. It was documented that all residents had received PREA resident education between one (1) and six (6) days of admission to the facility. The facility exceeds this subsection requirement.

Subsection (c): Facility policy requires all residents to receive the PREA training. Residents are not transferred between programs in the facility.

Subsection (d): Facility policy requires that resident PREA education is available in assessable formats for all residents including those who are limited English proficient, deaf, visually impaired, or otherwise disabled as required by this subsection. The facility has interpreting services available, staff that are bilingual and materials in English and Spanish throughout the facility. If additional accommodation is needed, the appropriate community resource will provide for that service.

Subsection (e): Facility policy requires the facility to maintain documentation of resident participation in PREA training. Residents must sign an acknowledgement form stating they have received the training and understand it. The auditor reviewed the tracking spreadsheet as verification of resident participation in such training. The Auditor reviewed Three (3) random resident files to corroborate this documentation was present. Interviews with residents further evidenced the training is occurring as residents are able to state the meaning of zero tolerance and the reporting mechanisms available to them to report abuse.

Subsection (f): Facility policy requires key PREA information is continuously and readily available to residents through posters, signage, resident handbooks or other written formats. During the tour, the Auditor observed PREA posters throughout the facility in both English and Spanish. All housing units have signage with key phone numbers and addresses of entities to whom the resident can report or contact for services.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Facility policy: Specialized Training: Investigations 12 Page
3. National Institute of Corrections (NIC) Web-based Training
4. Investigating Sexual Abuse in a Confinement Setting – PREA Online Training Center
<https://nic.learn.com/learncenter.asp?id=178416>
5. Interviews with the following:
 - a. Investigative Staff
6. Training documentation for Investigators

Findings (By Subsection):

Subsection (a): Facility requires that in addition to the general training provided to all employees, all investigators must also receive specialized training in conducting sexual abuse investigations in confinement settings. The facility has 22 individuals that have completed the PREA Resource Center training on Investigating Sexual Abuse in a Confinement Setting. The Auditor was provided with evidence of training completion of the 22 individuals who completed the training. An interview with a facility investigator corroborates this training was completed.

Subsection (b): Facility policy requires that the specialized training include the topics detailed in this subsection. The NIC training curriculum was reviewed and appears to be compliant with this requirement.

Subsection (c): Facility policy requires the facility to maintain documentation that investigators have completed the required specialized training. The Auditor was provided documentation to substantiate compliance.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy:
 - a. Specialized Training: Medical and Mental Health Care 12 Page
3. National Institute of Corrections (NIC) Web-based Training
 - a. Medical and Mental Health Care staff Certificate of Completion – PREA: Your Role Responding to Sexual abuse – National Institute of Corrections
 - b. Statement of Fact from the Executive Director regarding completion of required Medical and Mental Health staff training

4. Training documentation for Medical and Mental Health Staff
5. Interviews with the following:
 - a. Medical and Mental Health Staff

Findings (By Subsection):

Subsection (a): Facility policy requires the facility to train all full and part-time medical and mental health care practitioners who work regularly in the facility on PREA. The facility reports that there are two (2) medical and two (2) mental health practitioners at the facility and all four (4) had received this training.

Subsection (b): Facility prohibits medical staff employed by the facility from conducting forensic medical exams. This subsection is therefore not applicable.

Subsection (c): Facility policy requires the facility to maintain documentation that medical and mental health staff has received the specialized training required by this standard. The Auditor was provided with the documentation of this mandatory training completion for four (4) of the four (4) medical and mental health practitioners.

Subsection (d): Facility policy requires that all medical and mental health care practitioners at the facility also receive the training mandated for all employees. Training documentation was provided for all practitioners to demonstrate compliance with this subsection.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Screening for Risk of Sexual Victimization and Abusiveness [Page 13-14]
3. Objective Screening Instrument (Screening for Risk of Sexual Victimization and Abusiveness)
4. Spreadsheet documenting all resident screening
5. Interviews with the following:
 - a. Random Residents
 - b. Staff Responsible for Risk Screening
 - c. PREA Coordinator
 - d. PREA Compliance Manager
6. Resident Files (Reviewing screening/assessment documentation)

Findings (By Subsection):

Subsection (a): Facility policy requires that a resident have a vulnerability assessment conducted upon intake and no less than 72 hours of the resident’s arrival at the facility and periodically throughout a resident’s confinement. The facility reports in the PAQ that during the past 12 months, 587 youth whose length of stay was

for 72 hours or more were screened for risk of sexual victimization or sexual aggression. The Auditor reviewed resident files to determine if the vulnerability assessment was occurring within 72 hours and all files reviewed were compliant. Generally, the screening occurs on the same day of admission. The facility exceeds the requirements of this subsection.

Subsection (b): Facility policy requires the facility to use an Objective Screening Instrument (Screening for Risk of Sexual Victimization and Abusiveness).

Subsection (c): Facility policy requires the facility assessment process to attempt to ascertain information about 11 specific types of information enumerated by this standard. The objective screening instrument used by the facility complies with this section. Interviews with staff indicate they are complying with this standard.

Subsection (d): Facility policy requires staff to ascertain the information required by this standard through conversations with the resident during intake and medical and mental health screenings, during classification assessments and by review of relevant records of the youth. Interviews with staff indicate they are complying with this standard.

Subsection (e): Facility requires the facility to ensure that sensitive information gained during the assessment process is kept confidential and only disclosed to staff with the need to know. All information gained in the assessment/screening process is kept confidential and only staff with a need to know can access this data. The facility utilizes the Juvenile Case Management System (JCMS) for their automated record system. JCMS has role-based security protocols that help facility administration ensure that information is only accessed by those with a need to know and who have been given appropriate authorization and access.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy:
 - a. 115.342 Use of Screening information [Page 14-15]
 - b. Brazos County Juvenile Detention Center – Screening for Risk of Sexual Victimization and Abusiveness Form
3. Interviews with the following:
 - a. Superintendent
 - b. PREA Compliance Manager
 - c. Staff Responsible for Risk Screening
 - d. Medical and Mental Health Staff
4. Resident Files

Findings (By Subsection):

Subsection (a): Facility policy requires staff to make housing, bed, program, education, and work assignments for residents based on the information obtained in the screening process under Standard 115.341. Interviews with staff and review of resident files corroborate this policy is the practice of the facility.

Subsection (b): The facility has not and does not utilize isolation of residents at risk of sexual victimization. Interviews with a variety of staff corroborate that isolation is not used for residents at risk of sexual victimization.

Subsection (c): Facility policy prohibits placing lesbian, gay, bisexual, transgender, or intersex residents in particular housing assignments solely on the basis of such identification or status. Policy also states that a staff is prohibited from considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusing. There were no lesbian, gay and bisexual residents in the facility during the audit confirm that the residents are not placed in specific housing units based on their identification as lesbian, gay or bisexual.

Subsection (d): Facility policy states that a transgender or intersex resident's own view with respect to his/her own safety shall be given serious consideration. Staff making housing and programming assignments for transgender or intersex residents in the facility will be on a case-by-case basis and will require final approval from the Facility Administrator. During the on-site audit, there were no identified transgender or intersex residents at the facility. Interviews with staff indicate that housing and programming assignments is made on a case-by-case.

Subsection (e): Facility policy requires the facility to reassess the placement and programming assignments for each transgender or intersex resident at least twice a year.

Subsection (f): Facility policy requires staff to give serious consideration to a transgender or intersex resident's own views with respect to his or her safety. Interviews with the PREA Compliance Manager and screening staff indicate this would be the practice when the facility has a transgender or intersex resident.

Subsection (g): Facility policy provides that transgender and intersex residents shall have the opportunity to shower separately from other residents. Interviews with staff confirm this to be the practice as necessary. Showers in all single room living units in the facility are private with doors to ensure privacy. Showers in the Juvenile Detention Center are used by only one (1) resident at a time and allow for privacy. Interviews with staff indicated that additional precautions would be made for transgender or intersex residents to ensure the residents have complete privacy and that these residents would be allowed to shower one at a time and privately.

Subsection (h): Facility policy requires documentation of any residents placed in isolation including the basis for the isolation and the reason why no alternative means of separation could be achieved. The facility reports that in the past 12 months, there have been no residents at risk for sexual victimization placed in isolation.

Subsection (i): Facility policy requires that if a resident is at risk of sexual victimization and held in isolation, the facility will afford each such resident a review every 30 days by the facility administrator and supervisor to determine whether there is a continuing need for separation from the general population. The facility reports that in the last 12 months there have been no residents at risk for sexual victimization placed in isolation.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy 115.351 Resident Reporting [Page15-16]:
3. Facility posting of multiple internal and external reporting telephone numbers of sexual abuse or sexual harassment (English and Spanish)
4. Youth Admission Pamphlet (English and Spanish) – “Youth Safety Guide for Juvenile Services”
5. Resident Detention Handbook (English and Spanish) “A RESIDENT’S GUIDE TO SUCCESS IN THE BRAZOS COUNTY JUVENILE DETENTION CENTER”
6. Facility PREA Video
7. Postings on all living units and program areas
8. Staff PREA Training Curriculum
9. Interviews with the following:
 - a. facility PREA Compliance Manager,
 - b. random staff and residents
 - c. observation of facility programs,
 - d. housing units and programming areas during tour of physical plant noting PREA posters, signage and educational materials on display or readily accessible

Findings (By Subsection):

Subsection (a): Facility policy states that the agency shall provide multiple internal methods to privately report sexual abuse and sexual harassment, retaliation by other residents or staff and staff neglect or violation of responsibilities that may have contributed to such incidents. A resident may report these issues by verbally telling a staff member and/or by using the facility’s grievance process. Interviews with residents indicate that they understand their reporting options as a result of PREA education, posters, and signage. Staff interviews demonstrated that staff understand and can articulate the reporting mechanisms for residents.

Subsection (b): Facility policy identifies at least one way for residents to privately and anonymously report sexual abuse or sexual harassment to an external entity not affiliated with the agency identified as to the Texas Juvenile Justice Department (TJJD) abuse reporting phone line and/or to the Brazos County Sheriff’s Department. The TJJD toll-free phone number and the phone number to the Brazos County Sheriff’s Department are found on PREA posters throughout the facility common areas and housing areas. Interviews with residents demonstrate they understand they can call the hotline and how to request staff to allow them to use the phone.

Subsection (c): Facility policy requires facility staff to accept reports made verbally, in writing, anonymously, and from third parties and required to immediately, without delay report any verbal reports or a witness statement. Staff is required and follows mandatory reporting duties. Interviews with facility staff indicate their knowledge of and adherence to this policy and practice.

Subsection (d): Facility policy requires that residents shall have access to tools necessary to make a written report. Grievance forms are available from staff members and available in common areas. Facility policy requires staff will ensure blank grievance forms are available at all times to residents. The Auditor observed grievance forms and grievance deposit boxes during the tour of the facility housing units and common areas.

Interviews with residents demonstrated their understanding of the available reporting mechanisms such as the grievances.

Subsection (e): Facility policy provides that staff can privately report sexual abuse and sexual harassment of residents by reporting to their local law enforcement, TJJ, direct supervisor, shift supervisor, shift manager, facility administrator/PREA manager, Operations Manager or to the PREA Coordinator. Any such report must be immediately reported to the Facility Administrator. Interviews demonstrated that staff understands these reporting mechanisms 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. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy 115.352 - Exhaustion of administrative remedies [Pages 16-18]
3. **Grievance Forms available at facility website :**
[http://www.brazoscountytx.gov/index.aspx?NID=515New/PrisonRapeEliminationAct\(PREA\)/tabid/5330/language/en-US/Default.aspx](http://www.brazoscountytx.gov/index.aspx?NID=515New/PrisonRapeEliminationAct(PREA)/tabid/5330/language/en-US/Default.aspx)
4. Interviews with the following:
 - a. No Resident had reported sexual abuse
5. Observation of resident grievance forms and grievance boxes located in facility programs, housing units and programming areas during tour of physical plant

Findings (By Subsection):

Subsection (a): The Facility has an administrative procedure for dealing with resident grievances regarding sexual abuse and is not exempt from this standard. The PAQ documents that the facility reports that there have been no grievances filed alleging sexual abuse. During the facility on-site review, the Auditor observed placement of grievance forms in the housing units as well as secure grievance deposit boxes throughout the facility available to residents.

Subsection (b): Facility policy allows a resident to submit a grievance regarding an allegation of sexual abuse at any time regardless of when the incident is alleged to have occurred. Residents are not required to comply with the grievance procedures involving informal attempts to resolve issues for any grievance alleging sexual abuse or sexual harassment. Residents are not required to try to resolve with staff an alleged incident of sexual abuse.

Subsection (c): Facility prohibits the facility from requiring residents to submit a grievance alleging sexual abuse or sexual harassment to a staff member who is the subject of the complaint. The facility shall not refer the grievance to the individual who is the subject of the complaint. Policy is compliant with this subsection.

Subsection (d): Facility policy requires a decision on the merits of a grievance alleging sexual abuse or sexual harassment within 90 days of the initial filing of the grievance as required by this subsection. The policy complies with the requirements of this subsection relating to an extension of timeframes.

Subsection (e): Facility policy permits third parties, including fellow residents, staff members, family members, attorneys, etc. to assist residents in filing requests for administrative remedies as required by this subsection. The policy complies with the requirements of this subsection.

Subsection (f): Facility policy provides for an emergency grievance procedure for residents to report situations involving imminent risk of sexual abuse of a resident. Policy is compliant with the requirements of the subsection regarding timelines for resolution. The emergency grievance procedure is explained during the resident comprehensive education component. The resident education materials (i.e., handbooks, orientation documents) discuss PREA and the grievance procedure.

Subsection (g): Facility policy states that it may discipline a resident for filing a grievance related to alleged sexual abuse only where the facility demonstrates that the resident filed the grievance in bad faith. The facility had no documented instances of discipline of residents for bad faith grievances.

Corrective Action: None

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. Facility policy 115.353 Resident access to outside confidential support services [Pages 18-19]
2. Agency agreement between the Brazos County Juvenile Board and the SARC
3. Youth Admission Pamphlet (English and Spanish) – “Youth Safety Guide for Juvenile Services”
4. Resident Detention Handbook (English and Spanish) “A RESIDENT’S GUIDE TO SUCCESS IN THE BRAZOS COUNTY JUVENILE DETENTION CENTER”
5. Agency PREA Video
6. Facility PREA posters
7. Interviews with Facility Director, PREA Compliance Manager, random residents, and Director of the SARC.
8. Interviews with the following:
 - a. Random Residents
 - b. Residents who Reported a Sexual Abuse
 - c. Superintendent/Facility Administrator
 - d. PREA Compliance Manager
 - e. Telephone interview with Chief Nurse Executive, Vice President of Patient Care Services, St. Joseph Regional Hospital
 - f. Telephone interview with the Executive Director, Brazos County Rape Crisis Center (SARC)

9. Observation of signage and educational materials on display in facility programs (secure and non-secure), housing units and programming areas during tour of physical plant

Findings (By Subsection):

Subsection (a): Facility policy provides that residents have access to outside victim advocates for emotional support services related to sexual abuse. Residents are informed of these services during the comprehensive education training and through signage in living units. Interviews with residents indicate that the youth understand how to access these services, who provides these services or what these services include.

Subsection (b): Facility policy provides that staff inform residents that conversations and written correspondence may be monitored for the purposes of ensuring safety and security within the facility.

Subsection (c): Facility policy provides that the facility have agreements with community service providers for confidential emotional support for residents related to sexual abuse. The Brazos County Juvenile Services Department has agreements with the Brazos County Rape Crisis Center (SARC) and Patient Care Services, St. Joseph Regional Hospital. The Auditor spoke to both organizations and confirmed the agreement to provide the services required by this standard.

Subsection (d): Facility policy provides residents with reasonable and confidential access to their attorneys or other legal representatives and reasonable access to parents or legal guardians. Interviews with residents indicate the facility complies with these requirements.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy 115.354 Third Party reporting [Page 19]
3. Brazos County Juvenile Services Juvenile, Parent, Community Grievance Report Form
4. **Facility website at:**
<http://www.brazoscountytexas.gov/index.aspx?NID=515>

Findings (By Subsection):

Subsection (a): Facility policy provides mechanisms to receive third-party reports of sexual abuse and sexual harassment and distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident. Third parties can file a grievance on behalf of a resident and allege sexual abuse or sexual harassment. The Brazos County Juvenile Services Department website contains information on how to report as required by this standard.

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. Completed Pre-Audit Questionnaire
2. Facility Policy 115.361 Staff and agency reporting duties [Page19]
3. Interviews with the following:
 - a. Random Staff
 - b. Medical and Mental Health Staff
 - c. PREA Compliance Manager
 - d. Superintendent/Facility Administrator

Findings (By Subsection):

Subsection (a): Facility policy requires staff to report immediately any knowledge, suspicion or information received regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency, retaliation against residents or staff who reported an incident and any staff neglect or violations of responsibilities that may have contributed to an incident or retaliation. Interviews with staff demonstrate their knowledge of their reporting responsibilities under Texas law, facility policy and PREA regulations.

Subsection (b): Facility requires all staff to comply with mandatory child abuse reporting laws. Random staff interviews confirmed their responsibility to comply with facility policies and mandatory child abuse reporting laws.

Subsection (c): Facility policy requires that apart from reporting to the designated supervisors or officials and designated State or local services agencies, all staff to maintain that information in confidence except as necessary to make treatment/investigation and other security/management decisions.

Subsection (d): Facility policy requires medical and mental health staff to report abuse to designated supervisors and officials. As well as to the designated State or local services agency where required by mandatory reporting laws. Medical and mental health practitioners are required to inform residents of the limitations of confidentiality of their duty to report and the limitations of confidentiality. Interviews with medical and mental health staff confirm compliance with this standard relating to protection of confidential information and required disclosures.

Subsection (e): Facility policy requires the facility administrator or designee to promptly (within 1 hour of receipt) report the allegation to the Brazos County Sheriff's Department, TJJJ, and the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should

not be notified. If the victim is under the guardianship of DFPS the report shall be made to the caseworker instead of the parents or legal guardians. The allegation will also be reported to the victim's attorney or the youth's Juvenile Probation Officer within 14 days of receiving the allegation. Interviews with the PREA Compliance Manager and Facility Superintendent confirm practice follows policy.

Subsection (f): Facility policy requires the facility to report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators. Interviews with the facility superintendent/administrator confirmed this is the 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. Agency Policy 115.362 [Page 20] – Agency protection duties
2. Interviews with the following:
 - a. Facility Head
 - b. Superintendent/ Facility Administrator
 - c. Random Staff

Findings (By Subsection):

Subsection (a): Facility policy requires that when staff learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident. Staff shall take action to assess and implement appropriate protective measures without unreasonable delay. The administrator will take steps to separate the alleged victim from the alleged perpetrator. The alleged staff or resident abuser will not have contact with the victim. The PAQ documents that there have been no instances of this in the past 12 months. Interviews demonstrate all necessary actions to protect the resident would be taken

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. Completed Pre-Audit Questionnaire (PAQ)
2. Agency Policy 115.363 [Page 20] - Reporting to other confinement facilities
3. Interviews with the following:
 - a. Facility Head
 - b. Superintendent/Facility Administrator

Findings (By Subsection):

Subsection (a): Facility policy requires that upon receiving an allegation that a resident was sexually abused while in another confinement facility, the Facility Administrator must notify the administrator of the facility or appropriate office of the agency where the alleged abuse occurred and shall notify the appropriate investigative agency. The PAQ documents that the facility reports that there have been zero (0) allegations of this type received in the past 12 months. Further the PAQ also states that the facility has received no notifications from other facilities in the past 12 months. Interviews with the Facility Administrator indicated that this policy would be followed if such situation occurred.

Subsection (b): Facility policy requires that such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegations.

Subsection (c): Facility policy requires that the Facility Administrator will document the notification and also notify TJJD.

Subsection (d): Facility policy states that should the facility receive such notification, it shall ensure the allegation is investigated in accordance with policy. Interviews with the facility administrator confirm knowledge of this policy and stated that the policy would be followed should this situation occur.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Agency Policy 115.364 [Page 20-21]– Staff first responder duties
3. Staff training documents – training on first responder duties and responsibilities
4. Facility First Responder laminated card
5. Interviews with the following:

- a. Security Staff and Non-Security Staff First Responders
- b. Residents Who Reported a Sexual Abuse
- c. Random Staff

Findings (By Subsection):

Subsection (a): Facility policy correctly identifies first responder duties upon receiving an allegation that a resident was sexually abused as required by this standard. The PAQ documents that there have been no allegations of sexual abuse in the facility during the past 12 months. Interviews with staff demonstrated their knowledge of the first responder protocol. The Facility has provided staff with first responder cards that staff can carry in their wallet or ID badge to use when responding to an incident. Interviews with staff indicate an understanding of their first responder duties and an ability to articulate and explain the duties correctly.

Subsection (b): Facility policy distinguishes the first responder duties for security staff versus non-security staff. Interviews with random staff confirmed knowledge of their responsibilities.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy 115.365 [Page 21-22] – Coordinated response
3. Brazos County PREA First Responders Checklist and Coordinated Response poster.
4. Interview with Facility Director
5. Interviews with the following:
 - a. Superintendent/Facility Administrator
 - b. PREA Coordinator

Findings (By Subsection):

Subsection (a): Facility policy explains the manner in which the facility’s coordinated written institutional response plan operates to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership. Interviews with the Facility Administrator and PREA Coordinator confirmed the details of the written plan.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy 115.366 [Page 22-23] – Preservation of ability to protect residents from contact with abuser
3. Interviews with the following:
 - a. Facility Head

Findings (By Subsection):

Subsection (a): Brazos County Juvenile Services does not participate in any collective bargaining agreements. It does not enter into or renew any agreement that limits the agency’s ability to remove alleged staff sexual abusers from contact with residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.

Subsection (b): N/A

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. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy 115.367 [Page 23] - Agency Protection Against Retaliation
3. Agency Form 115.367 Sexual Abuse Retaliation Monitoring – to be used in instances of retaliation for reporting sexual abuse incidents
4. Interviews with the following:
 - a. Assistant Agency Executive Director

- b. PREA Compliance Manager
- c. Facility Administrator who is charged with monitoring for retaliation
- d. Residents who Reported a Sexual Abuse

Findings (By Subsection):

Subsection (a): Facility policy states that the facility shall protect all residents and staff who report sexual abuse or sexual harassment or cooperates with an investigation from retaliation by other residents or staff. The facility policy also states that appropriate measures will be taken, to include contacting the Sheriff’s Department, to protect the individual against retaliation. There have been zero (0) instances of alleged retaliations in the past 12 months.

Subsection (b): Facility policy states that the facility employs multiple protection measures such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abuser from contact with victims, and emotional support services for residents or staff that fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. Staff could articulate to the auditor the ways they would uncover retaliation and monitor retaliation.

Subsection (c): Facility policy requires the facility to continue monitoring for retaliation for at least 90 days following a report with a possible extension beyond 90 days if needed in compliance with this subsection. Facility policy also requires that the facility employ multiple protection measures such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abuser from contact with victims, and emotional support services for residents or staff that fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. Administrators and staff were knowledgeable about the duty to monitor for retaliation for the time periods in this standard as well as required procedure.

Subsection (d): Facility policy requires that for residents, such monitoring shall also include periodic status checks to be conducted by the Shift Supervisors. Status checks will be conducted randomly twice weekly and documented in the status checks binder in the supervisor’s office.

Subsection (e): Facility policy states that if any other individual who cooperates with an investigation expresses a fear of retaliation, the agency shall take appropriate measures to protect that individual against retaliation.

Subsection (f): Facility policy states the obligation to monitor shall terminate if the investigation determines the allegation is unfounded.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Agency Policy 115.368 – Post-allegation protective custody [Page 24]
3. Interviews with the following:
 - a. Superintendent/Facility Administrator
 - b. Medical and Mental Health Staff
 - c. Staff who Supervise Residents in Isolation

Findings (By Subsection):

Subsection (a): Facility policy 115.368 - Post-Allegation Protective Custody [Page 24] provides that the use of segregated housing to protect a resident who is alleged to have suffered sexual abuse shall be subject to the requirements of Standard 115. The PAQ documents that in the past 12 months there have been no residents who have alleged sexual abuse who were placed in isolation. The Auditor observed no residents in post-protective custody during the on-site audit tour. Staff interviews indicate that if isolation is ever used, the protections required by Standard 115.342 would be followed.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Agency policy 115.371 – Criminal and administrative [Pages 24-25]
3. MOU with the Brazos County Juvenile Services Department and the Brazos County Sheriff’s Department
4. Interviews with the following:
 - a. Investigative Staff
 - b. Facility Administrator,
 - c. PREA Compliance Manager,
 - d. Brazos County Sheriff’s Office Representative

Findings (By Subsection):

Subsection (a): This facility conducts administrative investigations and the Brazos County Sheriff’s Department conducts criminal investigations into allegations of sexual abuse and sexual harassment. Facility policy requires these investigations to be conducted promptly, thoroughly and objectively for all allegations, including third party and anonymous reports. In the past 12 months, the facility has conducted no administrative investigations and no referrals of sexual abuse (occurring in the facility) have been made to the Brazos County Sheriff’s Department for criminal investigations. Administrative investigations must also follow the administrative rules promulgated by the Texas Juvenile Justice Department contained in Title 37 Texas Administrative Code Chapters 358. The facility has multiple trained designated facility investigators.

The Auditor interviewed facility investigator staff who confirmed their knowledge of the requirements of this standard and all its subsection and further acknowledged that investigations are to be conducted in accordance with these requirements.

Subsection (b): The facility policy requires all facility investigators to have special training in sexual abuse investigations involving juvenile victims per Standard 115.334. Facility investigators have received training from the PREA Resource Center. Interviews with trained investigators confirmed completion of this training and could articulate the key components of the course related to investigations in correctional settings.

Subsection (c): The facility policy requires investigators to gather and preserve evidence, interview appropriate persons and review prior complaints involving the alleged perpetrator as required by this subsection. Interviews with investigative staff demonstrate knowledge of how to conduct investigations of this type.

Subsection (d): The facility policy prohibits the facility from terminating an investigation solely because the source of the allegation recants the allegation. Interviews with investigators confirmed their understanding of this requirement.

Subsection (e): The facility policy prohibits investigators from conducting compelled interviews in certain situations. The policy states “When the quality of evidence appears to support criminal prosecution, the facility shall conduct compelled interview only after consulting with prosecutors.”

Subsection (f): The facility requires investigators to assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the person’s status as a resident or staff. The policy requires the investigation to proceed and a polygraph examination cannot be used as a condition for proceeding with the investigation.

Subsection (g): The facility requires administrative investigations to include an effort to determine whether staff actions or failures to act contributed to the abuse. Additionally, facility policy requires investigators to document the investigation in written reports that include descriptions of the evidence, the reasoning behind credibility assessments, and investigative facts and findings.

Subsection (h): The facility policy requires that investigations shall be documented per TJJJ incident form requirements and investigation requirements including:

- a. Description of the physical and testimonial evidence,
- b. The reasoning behind credibility assessments, and
- c. Investigative facts and findings.

Subsection (i): The facility policy requires investigators to refer for prosecution substantiated allegations of conduct that appear to be criminal. There have been zero (0) substantiated allegations of conduct that appeared to be criminal.

Subsection (j): The facility policy requires that all written reports of administrative and criminal investigations shall be retained as long as the alleged abuser is incarcerated or employed by the agency plus five years, unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention.

Subsection (k): The facility policy states that the departure of the alleged abuser or victim from the employment or control of the facility shall not provide a basis for terminating an investigation.

Subsection (l): The facility policy requires that any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements. Interviews with facility investigators confirmed that TJJJ investigations follow the PREA standards.

Subsection (m): The facility policy requires the facility to cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation. Interviews with staff indicate that the facility maintains close contact with TJJ and Brazos County Sheriff's Department who conduct external investigations.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Agency Policy 115.372 – Evidentiary standard for administrative investigations [Page 26]
3. Interview with the following:
 - a. Investigative Staff

Findings (By Subsection):

Subsection (a): Facility policy states that it will impose no standard higher than a preponderance of evidence or a lower standard of proof for determining whether allegations of sexual abuse or sexual harassment are substantiated. The interview with facility investigators confirmed their knowledge of the required standard of proof and that the practice would be to use "preponderance of the evidence" in facility investigations.

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. Completed Pre-Audit Questionnaire (PAQ)

2. Facility Policy 115.373 Reporting to residents [Page 26-27]
3. Resident Allegation Notification Form
4. Interviews with the following:
 - a. Facility Administrator
 - b. Investigative Staff

Findings (By Subsection):

Subsection (a): The facility policy requires that any resident who makes an allegation that he or she suffered sexual abuse in the facility shall be informed verbally or in writing, of all notifications, as to whether the allegation has been determined to be substantiated, unsubstantiated or unfounded following an investigation by the agency. Interviews with the Facility Administrator and investigative staff confirmed this procedure. The PAQ documents that in the past 12 months, there were no criminal and/or administrative investigations conducted. The interview with the facility administrator and facility investigator confirmed that the notifications required under this section would be provided as a part of all investigations.

Subsection (b): The facility policy requires that relevant information will be requested from external investigators if the facility did not conduct the investigation in order to notify the resident. The PAQ documented that there had been no external investigations conducted in the past 12 months by the Brazos County Sheriff’s Department or TJJJ on PREA related conduct.

Subsection (c): Facility policy requires notification of the resident when 1) the staff member is no longer posted within the resident’s unit; 2) the staff member is no longer employed at the facility; 3) the staff member has been indicted; or 4) the staff member has been convicted on a charge related to sexual abuse within the facility.

Subsection (d): The facility policy requires the facility to provide notification to the resident (regarding abuse by another resident) when the abuser has been indicted or the abuser has been convicted on a charge related to sexual abuse within the facility.

Subsection (e): The facility policy requires the facility to document all such notifications or attempted notifications under this standard.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy Agency Policy 115.376 [Page 27] – Disciplinary sanctions for staff.

Findings (By Subsection):

Subsection (a): The facility provides that staffs that violate facility sexual abuse or sexual harassment policies are subject to disciplinary sanctions up to and including termination as required by this standard. In the past 12 months, the facility reports that no staff has violated the facility policy on sexual abuse or sexual harassment. No staff have been terminated, disciplined or resigned for PREA related conduct and no reports of staff misconduct/criminal behavior have been made to law enforcement.

Subsection (b): The facility policy provides that the facility shall terminate staff members found to have engaged in sexual abuse.

Subsection (c): The facility policy requires disciplinary sanctions to be commensurate with the nature and circumstances of the acts committee, the staff member’s disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories.

Subsection (d): The facility policy requires the facility to report all terminations for violations of policy on sexual abuse or sexual harassment, or resignations by staff that would have been terminated, if not for their resignation to TJJD and the Brazos County Sheriff’s Department, unless the activity was clearly not criminal.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy 115.377 Corrective Action for Contractors and Volunteers [Page 27-28]
3. Interviews with the following:
 - a. Facility Administrator

Findings (By Subsection):

Subsection (a): The facility policy states that the facility shall prohibit any contractor or volunteer, who engages in sexual abuse, from contact with residents and shall report to TJJD, local law enforcement agencies (unless not criminal conduct) and to relevant licensing bodies as required by this standard. In the past 12 months, the Facility reports that no contractors or volunteers have been reported to law enforcement for engaging in sexual abuse of residents. The interview with the Facility Administrator confirmed their knowledge of this requirement and indicated this would be the practice in the event such a situation occurs.

Subsection (b): The facility policy requires the facility to take appropriate remedial measures against a volunteer or contractor who violates the facility sexual abuse or sexual harassment policies. Contact with residents will be prohibited. The interview with the Facility Administrator indicated that no volunteer or contractor had violated the facility sexual abuse or sexual harassment policies.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy 115.378 Disciplinary sanctions for residents [Page 28]
3. Interviews with the following:
 - a. Superintendent/Facility Administrator

Findings (By Subsection):

Subsection (a): The facility policy provides that a resident may be disciplined after a substantiated finding in an administrative investigation or a criminal finding that a resident participated in the sexual abuse of another resident or staff in compliance with this standard. The PAQ documents that there have been no administrative or criminal findings regarding resident on resident sexual abuse that have occurred in the facility in the past 12 months. Interviews with Facility Administrators confirm their knowledge of the requirements of this standard related to resident discipline and acknowledge that practice would be followed in such an event.

Subsection (b): The facility policy requires any disciplinary sanctions for residents to consider the nature and circumstances of the abuse, the resident’s disciplinary history, the sanctions imposed for comparable offenses by other residents with similar histories, and whether a resident’s mental disabilities or mental illness contributed to his or her behavior. The policy requires that if isolation is used, the resident must be provided certain protections (i.e., educational programming, large-muscle exercise, medical/mental health visits) as detailed by this subsection which are all contained in the policy.

Subsection (c): The facility policy requires the discipline process to consider whether a resident’s mental disabilities or mental illness contributed to his or her behavior. The interview with the Facility Administrator indicated this is the procedure.

Subsection (d): The facility policy provides that the facility offers therapy and counseling for the resident. Participation in therapy or counseling is not required to access general programming or education services. Interviews with medical and mental health staff indicated that no resident had engaged in sexual abuse at the facility and that the resident would be offered therapy and counseling as required.

Subsection (e): The facility policy prohibits the facility from disciplining a resident for sexual contact with staff unless the staff member did not consent to such contact.

Subsection (f): The facility policy provides that a report of sexual abuse made in good faith shall not constitute a false report for disciplinary purposes.

Subsection (g): The facility policy prohibits all sexual activity between residents and disciplines residents.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy 115.381 Medical and mental health screenings; history of sexual abuse [Page28-29]
3. Facility Screening for Risk of Sexual Victimization and Abusiveness Form
4. Interviews with the following:
 - a. Residents who Disclose Sexual Victimization at Risk Screening
 - b. Staff Responsible for Risk Screening
 - c. Medical/mental health secondary materials

Findings (By Subsection):

Subsection (a): The facility policy requires the facility to offer a resident that has experienced prior sexual victimization a follow-up meeting with medical or mental health practitioners within 14 days of the intake screening. There were 67 residents during screening who disclosed prior sexual victimization, whether it occurred in an institutional setting or in the community. Resident interviews indicate follow-up medical and mental health care (counseling) is offered should residents wish to talk about their victimization with their counselors. The Auditor observed mental health secondary materials to demonstrate the residents were offered services and referred to appropriate services in the community. Interviews with staff who conduct the screening indicate that these follow-up services are provided.

Subsection (b): The Facility policy requires the facility to offer a resident that has previously perpetrated sexual abuse a follow-up meeting with medical or mental health practitioners within 14 days of the intake screening. There were five (5) residents who disclosed previous sexual abuse perpetration. Interviews with staff who conduct the screening indicate that these offered follow-up services had been provided. A sample of two (2) resident records confirmed that the services had been offered upon intake screening.

Subsection (c): Facility policy requires staff to keep information related to sexual victimization or abusiveness confidential. Resident information in the Texas Juvenile Justice Department JCMS system is confidential through role-based security.

Subsection (d): Brazos County Juvenile Detention center does not accept youth over the age of 18; pursuant PREA standard §115.381, informed consent from residents before reporting information about prior sexual victimization is not applicable to our facility. Interviews with mental health staff indicate that informed consent is obtained.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy 115.382 Access to emergency medical and mental health services [Page29]
3. Interviews with the following:
 - a. Medical and Mental Health staff
 - b. Residents who Reported a Sexual Abuse
 - c. First Responders

Findings (By Subsection):

Subsection (a): The facility policy provides that resident victims of sexual abuse shall receive timely unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgement. Interviews with medical and mental health staff confirm this is the practice.

Subsection (b): The facility policy provides if no qualified medical or mental health practitioners are on duty at the time of a report of recent abuse is made, the first responder shall take preliminary steps to protect the victim pursuant to PREA standard 115.362 and shall immediately notify the appropriate medical and mental health practitioners. The facility PAQ documents that there have been no allegations of sexual abuse in the previous 12 months that would require emergency medical treatment or crisis intervention services. Interviews with medical and mental health staff could demonstrate their knowledge of first responder protocols for acute cases of sexual abuse.

Subsection (c): The facility policy requires the facility to offer resident victims of sexual abuse timely information about and timely access to emergency contraception and sexually transmitted infection prophylaxis, in accordance with professional accepted standards of care, and where medically appropriate. Interviews with medical staff and the first responders confirm that this would occur at the local hospitals where the resident would be transported for the SANE exam.

Subsection (d): The facility policy provides that it shall offer these treatment services (under this standard) to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Interviews corroborate that victims are not charged for these treatment services.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy 115.383 On-going medical and mental health care for sexual abuse victims and abusers [Page 30]
3. Interviews with the following:
 - a. Medical and Mental Health staff
 - b. There were no residents who Reported a Sexual Abuse

Findings (By Subsection):

Subsection (a): The facility policy provides that the facility shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who are victims or have been victimized by sexual abuse in prison, jail, lockup, or juvenile facility. Interviews with medical and mental health staff indicate this is the practice and that the requirements of this standard are met with policy and the actual practice would be compliant with this standard if an incident of sexual abuse occurred in the facility.

Subsection (b): The facility policy provides the evaluation and treatment of such victims 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 the medical and mental health staff confirmed that such victims are provided required services. The auditor reviewed two (2) resident health assessments and confirmed those services had been provided.

Subsection (c): The facility policy provides that the facility shall provide such victims with medical and mental health services consistent with the community level of care. Interviews with the medical and mental health staff confirmed that such victims are provided required services.

Subsection (d): The facility policy provides that the facility shall offer pregnancy tests to resident victims of sexually abusive vaginal penetration that occurs while they are resident of any facility. There were no female residents who reported sexual victimization.

Subsection (e): The facility policy provides that if pregnancy results from a sexual assault, resident victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services. Interviews with the medical and mental health staff confirmed that such victims are provided required services. There were no residents who had reported a sexual abuse.

Subsection (f): The facility policy requires that tests for sexually transmitted infections, as medically appropriate, will be offered to resident victims of sexual abuse that occurs while they are residents of any facility. There were no residents who had reported a sexual abuse.

Subsection (g): The facility policy requires it to provide all treatment services to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. There were no residents who had reported a sexual abuse.

Subsection (h): The facility policy requires an attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and shall offer treatment when deemed appropriate by mental health. Interviews with the medical and mental health staff confirmed that such victims are provided required services and are offered these services upon learning of abuse upon the resident's intake process upon admission.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy 115.386 [Page 30]
3. Interviews with the following:
 - a. Superintendent/ Facility Administrator
 - b. PREA Compliance Manager
 - c. Incident Review Team Member

Findings (By Subsection):

Subsection (a): The facility policy requires a sexual abuse incident review to be conducted at the conclusion of every sexual abuse investigation, including incidents where there was not enough evidence to substantiate the allegation, unless the investigation shows the allegation is unfounded. The facility reports that in the past 12 months, there have been zero (0) sexual abuse investigations; thus, there have been no sexual abuse incident reviews yet conducted. Interviews with Facility Administrator, PREA Compliance Manager and Incident Team members indicate their knowledge and understanding of the sexual abuse incident review process as required.

Subsection (b): The facility policy requires the review to ordinarily occur within 30 days of the conclusion of the investigation.

Subsection (c): The facility policy provides that the review team shall include upper-level management officials; Chief Probation Officer, Administrative Designee, PREA Coordinator, Facility Administrator and Assistant Facility Administrator with input from line supervisors, investigators and medical or mental health practitioners. Interview with the Facility Administrator confirmed the parties of the review team.

Subsection (d): The facility policy requires that the review team shall consider:

- (a) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;
- (b) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or, gang affiliation; or was motivated or otherwise caused by other group dynamic at the facility;
- (c) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse (camera placement, blind spots, training curriculum, and program);
- (d) Assess the adequacy of the staffing levels in that area during different shifts;
- (e) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and
- (f) Prepare a report of its findings, including but not limited to determination made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submit such report to the Chief Probation Officer, Facility Administrator and PREA Compliance Manager. Interviews with facility staff indicate the considerations in this subsection would be a part of the team review.

Subsection (e): The facility policy requires that the facility administrator shall implement the recommendations for improvement, or shall document the reasons for not doing so.

Corrective Action: None.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Facility policy 115.387 Data Collection [Page 31]
3. PREA Annual Data Review and Corrective Action Plan dated May 17, 2016 for 2014 and 2015
4. Brazos County Juvenile Services PREA Data Collection May 23, 2016
5. BRAZOS COUNTY website:
<http://brazoscountytexas.gov/DocumentCenter/View/2014>
6. Interviews with the following:
 - a. Superintendent/ Facility Administrator
 - b. PREA Compliance Manager

Findings (By Subsection):

Subsection (a) and (c): The facility policy provides that it shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of

definitions. The data 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 (DOJ). The Auditor reviews the data collection and aggregate report and determined compliance with this section.

Subsection (b): The facility policy requires it to aggregate the incident-based sexual abuse data at least annually.

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

Subsection (e): The agency policy requires the facility to obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents. The facility does not contract for the confinement of its residents.

Subsection (f): The facility policy requires the facility, upon request, to provide all such data from the previous calendar year to the DOJ no later than June 30. The DOJ has not requested agency data as of the PREA audit report date.

Corrective Action: None.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Agency Policy Data review for corrective action 115.388 [Pages 31-32]
3. PREA Annual Data Review and Corrective Action Plan dated May 17, 2016
<http://brazoscountytexas.gov/DocumentCenter/View/2014>
4. R. J. Holmgreen Facility PREA Data Collection (2012-2016)
5. Interviews with the following:
 - a. Facility Head
 - b. Superintendent/ Facility Administrator
 - c. PREA Coordinator
 - d. PREA Compliance Manager

Findings (By Subsection):

Subsection (a): The facility policy requires the facility to review data collected and aggregated under Standard 115.387 annually to assess and improve the effectiveness of sexual abuse prevention, detection, and response policies, practices, and training including: 1) identifying problem areas; 2) taking corrective action on an ongoing basis; and 3) preparing an annual report for each facility and the department as a whole. Interviews with Facility administration indicate this process is in place as required by this standard. Interviews with facility

administration indicate their knowledge of the data review required by this section and they articulated appropriately and effectively how they will use this process to improve their overall PREA compliance and the sexual safety of the facility.

Subsection (b): The facility policy requires the report to include a comparison of the current year’s data and corrective actions with those from prior years and shall provide an assessment of the facility’s progress in addressing sexual abuse. The Auditor reviewed the facility’s PREA Data Collection which documents data comparisons from 2012-2016.

Subsection (c): The facility policy requires the Executive Director to approve the report and make it readily available to the public through the Brazos County website. The Auditor verified the data and report approved by the Executive Director are posted on the facility website.

Subsection (d): The facility policy states that the department will redact any specific information from the reports when publication of such information would present a clear and specific threat to the safety and security of the facility. The Brazos County Juvenile Services Department shall indicate the nature of the material redacted (when applicable). The agency has not redacted any information from the report that would present a clear and specific threat to the safety and security of the facility.

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. Completed Pre-Audit Questionnaire (PAQ)
2. Brazos County Juvenile Services Department Policy Data storage, publication, and destruction 115.389 [Page 32]:
3. PREA Annual Data Review and Corrective Action Plan dated May 17, 2017
4. BRAZOS COUNTY website:
<http://www.brazoscountytexas.gov/index.aspx?NID=515>
5. Interview with the following:
 - a. PREA Coordinator

Findings (By Subsection):

Subsection (a): Brazos County Juvenile Services Department requires it to ensure that all data collected pursuant to Standard 115.387 are securely retained. The PREA Coordinator confirmed compliance with this standard.

Subsection (b): Brazos County Juvenile Services Department] requires it to make all aggregated sexual abuse data from facilities under its direct control, and private facilities with which it contracts, readily available to the

public through the Brazos County website on an annual basis. The Auditor reviewed the data on the website for compliance.

Subsection (c): Brazos County Juvenile Services Department requires it to remove all personal identifiers prior to making aggregated sexual abuse data publicly available. The Auditor reviewed the aggregated data and no personal identifiers were present.

Subsection (d): Brazos County Juvenile Services Department requires that unless Federal, State or local laws requires, the department shall maintain all abuse data collected pursuant to PREA Standard 115.387 for at least 10 years after the date of its initial collection.

Corrective Action: None.

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 facility 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.

Glen E. McKenzie, Jr.

July 19, 2017

Auditor Signature

Date