PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: 9-08-2016

Auditor Information			
Auditor name: David "Will" Weir			
Address: POB 1473 Raton New Mexico 87740			
Email: Will@preaamerica.com			
Telephone number: 405-945-1951			
Date of facility visit: August 09, 2016			
Facility Information			
Facility name: Webb County Youth Village			
Facility physical address: 111 Camino Nuevo Road, Laredo, TX., 78043			
Facility mailing address: *(if different from above)*			
Facility telephone number: (956) 523-5600			
The facility is:	☐ Federal	☐ State	☒ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☐ Correctional	☒ Detention	☐ Other
Name of facility's Chief Executive Officer: Jesus Del Toro			
Number of staff assigned to the facility in the last 12 months: 40			
Designed facility capacity: 72			
Current population of facility: 25			
Facility security levels/inmate custody levels: Medium			
Age range of the population: 10-17			
Name of PREA Compliance Manager: Carlos Morales		**Title:** PREA Coordinator	
Email address: carmorales@webbcountytx.gov		**Telephone number:** (956) 523-5678	
Agency Information			
Name of agency: Webb County Youth Villiage			
Governing authority or parent agency: *(if applicable)* Webb County Juvenile Board			
Physical address: 111 Camino Nuevo Road, Laredo, TX., 78043			
Mailing address: *(if different from above)*			
Telephone number: (956) 523-5600			
Agency Chief Executive Officer			
Name: Melissa L. Mojica		**Title:** Chief Probation Officer	
Email address: juvenile@webbcountytx.gov		**Telephone number:** (956) 523-5620	
Agency-Wide PREA Coordinator			
Name: Carlos Morales		**Title:** PREA Coordinator	
Email address: carmorales@webbcountytx.gov		**Telephone number:** (956) 523-5678	

AUDIT FINDINGS

NARRATIVE

PREAmerica LLC was retained on 08-13-2015 by the Texas Juvenile Justice Department (TJJD) to perform the PREA Juvenile Facility Audit for Webb County. Notices of the on-site audit went up by June 14, 2016 and the Pre-Audit Questionnaire was received by July 20, 2016. The on-site audit was conducted as planned on August 9. PREAmerica Auditor Will Weir and Project Manager Tom Kovach met with Agency Juvenile PREA Coordinator Carlos Morales and he organized an Opening Meeting. In addition to the Audit Team and Mr. Morales, attending the Opening Meeting were: Chief Juvenile Probation Officer Melissa Mojica, Assistant Chief Probation Officer Gerardo Liendo, Facility Administrator Jesus Del Toro, Assistant Facility Administrator Carlos Gonzalez, and Director of Operations Sandra Munoz. Introductions were made, questions answered, the audit itinerary was reviewed and the audit team was given current rosters of residents and staff before Administrators Del Toro and Gonzalez took the auditor of a facility tour. Random interviews were conducted by the audit team with residents and staff. Documents were reviewed and an Exit Conference, attended by the same officials, was held at the conclusion of the on site audit. Eleven residents were interviewed: seven females and 4 males. A total of 13 staff were interviewed including administrators. The audit team was impressed by the professionalism of the staff, and the positive morale of the residents who reported that they know everything they want to know about PREA and that they feel safe at Webb County.

Partial List of Documentation Reviewed by Audit Team:
Child Abuse Registry Check Release Form; Disclosure of PREA Employment Standards Violation Form; Pre Audit Questionnaire; Investigator's Training; MOU-CAC; PREA Pat Searches Training; PREA PPT Training; Resident PREA Video; Rulebook; various contracts; Behavioral Form; Health Screening Form; MAYSI-2 Form; Orientation Script; PREA Acknowledgement Form; Rule Receipt Form; Suicide Check List Form; Reports/Allegations from other agencies; Organizational Chart; facility schematic; PREA Policy; Daily Population Rosters; Unannounced Rounds Log; Staffing Plan and Review; Staff Training Logs and Curriculm; Intake Forms; PREA Screening Forms; Mission Statement; Employment Application and Addendum; Background checks from random personnel files; Coordinated Response; Postings and Notices;

DESCRIPTION OF FACILITY CHARACTERISTICS

The Webb County Youth Village, also known as the Judge Solomon Casseb, Jr., Youth Village, is a two level building and was opened in 2009 with the motto “It takes a village to raise a child.” The main building is for the parole unit and the detention facility is accessed through a locked passage way. There are two side by side doors: one opens to the visitation room and the other leads to the secure detention area. The Detention Center has 6 pods with single occupancy cells. There are 8 disciplinary cells.

As you enter the facility, the administrator’s office is to the right. The door to the left goes to the resident side of visitation. A long hallway gives access to the three pods. Each pod is two levels the first is the female pod the second and third are for males. There are 12 cells per level. Stairs in the center lead to the second level. The restrooms are in opposite corners as you enter.

Past the administrator’s office is a short hall leading to Intake. There is a large open area with a desk for staff and rows of seats for incoming residents. Off to the side are holding cells for overflow and a restroom for intake showering. A door at the back of the room leads to the Sally port. Closer to the administrator’s office is a couple of restrooms and storage.

Back in the main hall past the hall leading to intake is Control. On the other side of control is the Observation Unit A wall faces the hall and a row of cells facing one another can be viewed by control, although this area is not used.

The Gym is further down the hall, opposite pod 2, and has restroom that is not in use. On the side closest to “observation” is the kitchen which is located behind observation and has an opening to the gym.

Opposite the third pod is horse shoe wing that has 2 male and a female class rooms on the outside with a computer lab and library in between them. The inside has restrooms and two offices. There is a fenced outdoor area.

A camera system with 30 day retention is being replaced and augmented with over 30 new cameras, eliminating blind spots and improving the supplementation of staff supervision.

SUMMARY OF AUDIT FINDINGS

The Webb County Youth Village, also known as the Judge Solomon Casseb, Jr., Youth Village, received its on-site PREA audit on August 9, 2016. PREA Auditor Will Weir has verified compliance through interviews and a review of documents and found the facility to be fully compliant with all PREA Standards based on their successful completion of the PREA Audit process. They have exceeded standards in six areas.

Number of standards exceeded: 6

Number of standards met: 35

Number of standards not met: 0

Number of standards not applicable: 0

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment, and a policy outlining how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment and it includes sanctions for those found to have participated in prohibited behaviors. The policy includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents. According to the agency's policy there is a commitment to zero tolerance and safety. The agency employs and designates an upper-level, agency-wide PREA coordinator, Carlos Morales who has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in the facility. He also serves as the PREA Compliance Manager since the agency only operates one facility.

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)

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The Webb County Juvenile Board contracts with the Webb County Juvenile Probation Department which operates the Webb County Juvenile Detention Center. The agancy has a number of contracts for the confinement of residents from other agencies. These contracts require Webb County to be compliant with PREA. Also, Webb County contracts out for the confinement of its juveniles and it requires PREA compliance, as verified in contracts reviewed by the auditor.

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)

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recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The agency/facility develops, documents, and makes its best efforts to comply with a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against abuse. In calculating adequate staffing levels and determining the need for video monitoring, it takes into consideration: Generally accepted juvenile detention and residential practices; Any judicial findings of inadequacy; Any findings of inadequacy from Federal investigative agencies; Any findings of inadequacy from internal or external oversight bodies; All components of the facility's physical plant (including "blind spots" or areas where staff or residents may be isolated); The composition of the resident population; The number and placement of supervisory staff; Institution programs occurring on a particular shift; Any applicable State or local laws, regulations, or standards; The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and Any other relevant factors. Since August 20, 2012, the average daily number of residents has been 30, less than the number of residents on which the staffing plan was predicated 48, with no deviations from the ratios in the last 12 months. The facility is obligated to maintain staffing ratios of a minimum of 1:8 during resident waking hours and 1:18 during resident sleeping hours. Plans are to increase these by October 1, 2017. At least once every year the agency, in collaboration with the PREA Coordinator, reviews the staffing plan to see whether adjustments are needed to: the staffing plan; prevailing staffing patterns; the deployment of monitoring technology; or the allocation of agency or facility resources to commit to the staffing plan to ensure compliance with the staffing plan. The facility requires that intermediate-level or higher-level staff conduct unannounced rounds to identify and deter staff sexual abuse and sexual harassment. The agency/facility documents unannounced rounds on all shifts with a prohibition of staff alerting other staff of the conduct of the rounds. Documents provided, including recent staffing plan review, as well as interviews conducted, verify compliance with this standard.

Standard 115.315 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility does not conduct cross-gender strip or cross-gender visual body cavity searches of residents. Interviews indicate this policy has not been violated, and there has not been exigent circumstances requiring cross-gender searches. The facility policy requires that all cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches be documented and justified if they occur. Policies and procedures require staff of the opposite gender to announce their presence when entering a resident housing unit or area where residents are likely to be showering, performing bodily functions, or changing clothing. The facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. No such searches occurred in the past 12 months. Interviews conducted (of both staff and residents), and documentation received, indicate staff are properly trained, cross gender employees are announced, and searches are conducted by the book. Assisting successful compliance with this standard, Webb County policy mandates staff of each gender be on duty at all times, with the exclusion of documented/approved exceptions.

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.

The agency has established procedures to provide disabled residents equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The agency has established procedures to provide residents with limited English proficiency equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Agency policy prohibits use of resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under ß 115.364, or the investigation of the resident's allegations. In the past 12 months, there have been no instances where resident interpreters, readers, or other types of resident assistants have been used and it was not the case that an extended delay in obtaining another interpreter could compromise the resident's safety, the performance of first-response duties under ß 115.364, or the investigation of the resident's allegations. Staff and residents indicate the agency will go the extra mile to assist anyone to understand what they need to understand in order to be safe and exercise their rights. Staff interviews and policy reviews indicate these efforts have been required and practiced in the agency culture for a number of years. Exceeding PREA Standards, Webb County also mandates that residents with disabilities receive full educational services appropriate for their needs. Section 343.491 of agency policy in effect since Jan. 1, 2015, states: "Special Education: A. Coordination with the local education agency (LEA) will ensure that residents with disabilities are provided with a free and appropriate public education as determined by the ARD Committee in order to meet the individual educational needs of the student as defined by federal and state laws. B. Coordination with the local LEA will ensure that residents with disabilities have available an instructional day that is commensurate with that of other students." This policy also mandates the library support these goals, "Books, magazines, newspapers, reference materials, recreational books, etc., that will meet the residents' educational and recreational needs and requests will be available to all residents… Materials shall be selected to serve the interest and needs of the residents and shall reflect racial and ethnic interest and be age-appropriate for all levels."

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)

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The agency policy prohibits hiring or promoting anyone who may have contact with residents, and prohibits enlisting the services of any contractor who may have contact with residents, who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section. The Agency policy requires the consideration of 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. Agency policy requires that before it hires any new employees who may have contact with residents, it conducts criminal background record checks, consults any child abuse registry maintained by the State or locality in which the employee would work; and consistent with Federal, State, and local law, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. During the past 12 months 22 staff and or contact persons who may have contact with residents who have had criminal background record checks. The Agency policy requires that either criminal background records checks be conducted at least every five years of current employees and contractors who may have contact with residents or that a system is in place for otherwise capturing such information for current employees. The Agency policy states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. Unless prohibited by law, the agency shall 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. Compliance with this standard was verified through a close reading of policy and other documentation provided, as well as a review of random personnel files pulled at the auditor's request, and through interviews with administrators, including HR Director. Exceeding standards, the State of Texas Department of Public Safety operates the FAST system which maintains an ongoing criminal background history of employees, and alerts Webb County of any new record or event.

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)

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The agency or facility has has not acquired a new facility or made a substantial expansion or modification to existing facilities since August 20, 2012. The facility has a modern video monitoring system which is maintained and upgraded. Documentation provided, as well as interviews with administrators, indicate PREA will be considered when updates occur in the future.

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.

The agency/facility is responsible for conducting administrative investigatoins, while the Webb County Sheriff's Department is responsible for criminal sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). Other entities may also have the criminal investigative responsibilities depending on circumstances and jurisdictions. When conducting a sexual abuse investigation, the investigators follow a uniform evidence protocol that is developmentally appropriate for youth and based on the most recent edition of the DOJ's Office on Violence Against Women publication, A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents, or similarly comprehensive and authoritative protocols developed after 2011. As verified by policy and interviews all residents who experience sexual abuse have access to off site forensic medical examinations. These examinations are offered without financial cost to the victim and are conducted by Sexual Assault Forensic Examiners (SAFEs) or (SANEs). When SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations. The facility documents efforts to provide SANEs or SAFEs. These PREA Polices and Procedures, and were verified in line staff interviews as well, when staff remember these available services when recanting their first responder duties. No forensic medical exams have been performed during the past 12 months because there were no allegations indicating an exam. The facility attempts to make a victim advocate from a rape crisis center available to the victim, in person or by other means and these efforts are documented. This is provided through the Children's Advocacy Center of Laredo-Webb County, with whom the Agency has a Memorandum of Understanding (MOU), but if they are not available to provide victim advocate services, the facility provides a qualified staff member. In addition to having access to local and regional hospitals, the facility has an infirmary and a contract physician, Dr. Carlos Hornedo, who is trained and available to coordinate care.

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.

The facility and the agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. The agency has a policy, which appears to have been followed, that requires that allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, including the agency if it conducts its own investigations, unless the allegation does not involve potentially criminal behavior. The agency documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigation. Abuse, or even failure to cooperate in an investigation, can include termination of employment, according to these policies. The only allegations received in the past 12 months reviewed (June to June) were regarding residents no longer at the facility when allegations were made and then investigated by/with TJJD. Sexual abuse/harassment was not substantiated.

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)

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As verified by interviews with staff, the facility and the agency trains all employees who may have contact with residents on the following required matters: zero-tolerance policy for sexual abuse and sexual harassment; how to fulfill responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; residents' right to be free from sexual abuse and sexual harassment; the right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment; the dynamics of sexual abuse and sexual harassment in juvenile facilities; the common reactions of juvenile victims of sexual abuse and sexual harassment; how to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents; how to avoid inappropriate relationships with residents; how to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities, and including relevant laws regarding the applicable age of consent. Such training is tailored to the gender, as well as any unique needs and attributes of residents. In the past 12 months all staff employed by the facility, who may have contact with residents, were trained in PREA requirements. Between trainings, the agency provides employees with refresher information about current policies regarding sexual abuse and sexual harassment in handouts and staff meetings at least annually. The agency documents that employees understand the training they have received through employee signature. This verification was provided to the auditor.

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)

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Volunteers and contractors who will have contact with residents have to be trained on their responsibilities under the agency policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response, although there are no active volunteers at this time. The level and type of training provided to volunteers and contractors is based on the services they will provide and level of contact they will have with residents. All volunteers and contractors who will have contact with residents will have been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. The agency will maintain documentation confirming that volunteers/contractors understand the training they have received.

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.

Facility residents receive information at the time of intake about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. Webb County Policy requires this usually within 6 hours (see page 92 of Policy in place since Jan. 1, 2015) of admission. The facility provides resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills. In addition to providing such education, the agency ensures that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats. Residents admitted during the past 12 months have received this information in an age appropriate fashion, according to interviews and information provided. Many have received the information at previous placements as well. The agency maintains documentation of resident participation in PREA education sessions and this was provided to the auditor. The agency ensures that key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats, as verified in interviews of staff and residents, and observed by the audit team during the facility tour.

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)

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The agency does its own adminstative but not criminal investigations. Five agency investigators have been trained. Specialized training

includes techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. Investigating agencies are required to maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations. Documentation reviewed, and interviews with administrators, verify that the facility does investigate sexual abuse allegations at this time, and cooperates with other investigative authorities, and collects information needed to make determinations regarding resident treatment and safety.

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)

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The agency has a written policy related to the training of medical and mental health practitioners who work regularly in its facilities. The training includes: How to detect and assess signs of sexual abuse and sexual harassment; How to preserve physical evidence of sexual abuse; How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and How and to whom to report allegations or suspicions of sexual abuse and sexual harassment. There are two medical staff at this facility but they do not conduct forensic exams. They have received PREA training and are available to assist in coordinating care consistent with health needs, PREA Standards, and the agency Coordinated Response Plan.

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.

The agency has a policy that requires screening (upon admission to the facility or transfer from another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents within 72 hours of their intake. Exceeding standards, the facility conducts these screenings within 48 hours of admission. These assessments are conducted using objective screening instruments. The agency attempts to ascertain information about: (1) Prior sexual victimization or abusiveness; (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse; (3) Current charges and offense history; (4) Age; (5) Level of emotional and cognitive development; (6) Physical size and stature; (7) Mental illness or mental disabilities; (8) Intellectual or developmental disabilities; (9) Physical disabilities; (10) The resident's own perception of vulnerability; and (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents. This information is ascertained through conversations with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files. Controls are in place on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not

exploited to the resident's detriment by staff or other residents. The facilty reassesses when a resident is high risk and when new information regarding risk factors come to their attention. In excess of minimum standards, Webb County has a long standing policy of involving qualified and credentialed mental health professionals in their screenings. Current policy mandates a continuation of the exhaustive mental health screening program which was in place. Current PREA policy states on page 6, "Residents will be screened by the intake officer for the risk of sexual victimization and abusiveness using the facility behavioral screening and medical health screening forms." It goes on to say, "Information will be obtained through conversations with the resident, medical and mental health screenings, during classification assessments, and by reviewing court records, case files, facility behavioral records and other relevant documentation from the resident's files." The screening process to provide the highest quality of screenings for residents has been in place for a number of years, overtly including nearly all the minimum PREA standards for screenings, which were clarified with early PREA policy updates. In addition to detailed interviews with screeners, the auditor verifies the continunity of this routine level of professional participation. Page 6 and 7 of the policies effective January 1, 2015 state: "2. Behavioral Health Assessment – A mental health assessment conducted by a masters-level mental health provider who is licensed by one of the boards listed in paragraph (35) of this section and is qualified by training to conduct all required elements of a behavioral health assessment. A behavioral health assessment must include the following elements: a. clinical interview; b. psycho-social evaluation, to include: c. review of the following files and associated records in the possession of the juvenile probation department: (1) juvenile probation records; (2) mental health records; (3) medical records; (4) previous mental health testing records, and (5) educational records; d. parent/guardian interview, unless the parent/guardian is unwilling to participate, and any other collateral interviews the mental health provider deems appropriate, such as a teacher or the child's juvenile probation officer; e. psychometric testing, using instruments that are recognized and accepted by the American Psychological Association or another professional mental health organization, to include: (1) achievement assessment, only if there is no record of an achievement assessment within the last three years; (2) personality assessment, only if there is no record of a personality assessment within the last three years; (3) intellectual assessment, only if: (I) there is no record of an intellectual assessment within the last three years, or (II) a new intellectual assessment is indicated by: (-a-) pervasive use of drugs known to impair thought processes; (-b-) traumatic brain injury; (-c-) the child was age 12 or younger on the date of the most recent psychometric testing, or (-d-) obvious impairment in cognitive or interpersonal functioning; f. diagnostic impression, and g. review of risks, strengths, and recommendations for intervention." Also, in excess of PREA standards for screenings, the mental health professionals involved in this process since January 2, 2015 are licenced.

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.

The agency/facility uses information from the risk screening required by ß115.341 to inform housing, bed, work, education, and program assignments. The facility prohibits placing lesbian, gay, bisexual, transgender, or intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status. The facility prohibits considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. The agency or facility makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis. The facility uses all information obtained pursuant to § 115.341 and subsequently to make housing, bed, program, education, and work assignments for residents with the goal of keeping all residents safe and free from sexual abuse. Residents may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged, none where placed in protective custody in the past 12 months. Placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident. A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration. Transgender and intersex residents shall be given the opportunity to shower separately from other residents. The residents interviewed assured the worker that the screenings are done in a meaningful and confidential way to assist them and other residents be safe. The policy update effective January 1, 2015 verifies that the facility has been exceeding this standard for more than 12 months. In addition, it mandates a high level of confidentiality. On page 7 it defines: "Confidential Setting – A room or area that provides sound separation from other residents and unauthorized staff."

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.

The agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. The facility provides at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the facility. This can be accomplished by calling TJJD's 24-hour toll-free number 1-877-786-7263. There are no residents detained solely for civil immigration purposes, so a portion of this standard is not applicable. The agency has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. Staff are required to document verbal reports by the end of their shifts. The facility does provide residents with access to tools to make written reports of sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. The agency has also established procedures for staff to privately report sexual abuse and sexual harassment of residents. This can also be accomplished by calling TJJD's 24-hour toll-free number 1-877-786-7263.

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.

The facility has an administrative procedure for dealing with resident grievances regarding sexual abuse. The 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. There is no time limit for a resident to submit a grievance regarding an allegation of sexual abuse, and the resident is not required to use an informal grievance process, or otherwise to attempt to resolve with staff, an alleged incident of sexual abuse. The facility's policy allows a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. The facility's procedure requires that a resident grievance alleging sexual abuse not be referred to the staff member who is the subject of the complaint. The facility has policy that requires that a decision on the merits of any grievance or portion of a grievance alleging sexual abuse be made within 90 days of the filing of the grievance. The facility notifies the resident in writing when the agency files for an extension, including notice of the date by which a decision will be made. The facility policy permits third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and to file such requests on behalf of residents. Policy requires that if the resident declines to have third-party assistance in filing a grievance alleging sexual abuse, the agency documents the residents decision to decline. Policy allows legal guardians of residents to file a grievance, including appeals, on behalf of such resident, regardless of whether or not the resident agrees to having the grievance filed on their behalf. The agency has a policy for filing an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. These emergency grievances require an initial response within 48 hours and that a final agency decision be issue within 5 days. Interviews conducted, and documentation received, indicate there was one grievance alleging sexual abuse or

harassment that was filed in the past 12 months. The agency has a policy that limits its ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith.

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.

The facility provides residents access to outside victim advocates for emotional support services related to sexual abuse by giving residents (by providing, posting, or otherwise making accessible) mailing addresses and telephone numbers (including toll-free hotline numbers where available) of local, State, or national victim advocacy or rape crisis organizations. The agency has an MOU, which has been verified by the auditor, with The Child Advocacy Center; 111 N. Merida Drive; Laredo, TX 78043; 956-712-1840. This information is given to each resident and also posted around the facilty.

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.

The agency or facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment by phone, email, in writing, and by personal contact. The agency or facility publicly distributes information on how to report resident sexual abuse or sexual harassment on behalf of residents.

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.

Interviews with staff and administrators, as well as a review of policy, verify that all staff are required to report immediately: Any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency. They also must report any retaliation against residents or staff who reported such an incident. They must report staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The agency requires all staff to comply with any applicable mandatory child abuse reporting laws. Apart from reporting to designated supervisors or officials and designated State or local service agencies, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. Medical and mental health professionals are required to report sexual abuse to designated supervisors, as well as to the designated State or local services agency where required by mandatory reporting laws. Such practitioners shall be required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality. Upon receiving any allegation of sexual abuse, the facility head or his or her designee shall promptly report the allegation to the appropriate agency office and to 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 alleged victim is under the guardianship of the child welfare system, the report is be made to the alleged victim's caseworker instead of the parents or legal guardians. If a juvenile court retains jurisdiction over the alleged victim, the facility head or designee will also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation. The facility shall report all allegations of sexual abuse and sexual harassment, including third party and anonymous reports, for investigation.

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.

When the agency or facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident. Interviews indicate staff take this responsibility very seriously. In the past 12 months, there were no times the agency or facility determined that a resident was subject to substantial risk of imminent sexual abuse.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency policy requires that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the Facility Director must notify the head of the facility where sexual abuse is alleged to have occurred, as well as notifying the appropriate investigative agency. In the past 12 months, no allegations have been received that a resident was abused while confined at another facility. The agency

policy requires that the facility head provides such notification as soon as possible, but no later than 72 hours after receiving the allegation. The agency or facility documents that it has provided such notification within 72 hours of receiving the allegation. Policy also requires that allegations received from other facilities/agencies are investigated in accordance with the PREA standards.

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.

The agency/facility has a first responder policy for allegations of sexual abuse. The agency policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to: preserve and protect any crime scene until appropriate steps could be taken to collect any evidence; request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. Staff indicate they understand first responder duties. Training logs and training curriculum indicate all duties are covered.

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.

The facility has developed a written institutional plan 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, and this was provided to the auditor.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

The agency/facility is not part of a Collective Bargaining Contract and maintains its ability to protect it's residents and employees from abusers.

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.

The agency/facilty has a policy to protect all residents and staff or any cooperating individual who reports sexual abuse or sexual harassment or cooperates with sexual abuse or sexual harassment investigations from retaliation by other residents or staff. Staff member(s) or department(s) are charged with monitoring for possible retaliation. PREA Compliance Manager Carlos Morales is charged with monitoring retaliation at the facility. He monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff. He examines resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. He understands that his responsibilities require him to continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need. In the case of residents, such monitoring will also include periodic status checks. The agency/facility acts promptly to remedy any such retaliation.

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.

The facility has a policy that residents who allege to have suffered sexual abuse may only be placed in isolation as a last resort. The facility policy requires that residents who are placed in isolation because they allege to have suffered sexual abuse have access to legally required educational programming, special education services, and daily large-muscle exercise. In the past 12 months no residents who have alleged sexual abuse have been placed in isolation or segregated.

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.

Webb County Juvenile Detention Center has a policy related to criminal and administrative agency investigations. All sections of this standard have been added to the agency's written policies. The agency does not terminate an investigation solely because the source of the allegation recants the allegation. Substantiated allegations of conduct that appear to be criminal are referred for prosecution. The agency retains all written reports pertaining to the administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. When the quality of evidence appears to support criminal prosecution, the investigative agency will conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. The credibility of an alleged victim, suspect, or witness will be assessed on an individual basis and not be determined by the person's status as resident or staff. No polygraphs are required. Administrative investigations, conducted by the agency include an effort to determine whether staff actions or failures to act contributed to the abuse. Such investigations will be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. Criminal investigations will be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible. The agency will retain all written reports for 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. The departure of the alleged abuser or victim from the employment or control of the facility or agency will not provide a basis for terminating an investigation. When outside agencies investigate sexual abuse, the facility will cooperate with outside investigators and will endeavor to remain informed about the progress of the investigation.

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.

Written policy and interviews with administrators verify that the agency imposes a standard of a preponderance of the evidence when determining whether allegations of sexual abuse or sexual harassment are substantiated.

Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy requires that any resident who makes an allegation that he suffered sexual abuse is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency. In the past 12 months there have been 0 criminal and 2 administrative investigations of alleged resident sexual abuse that were completed. If an outside entity conducts such investigations, the agency requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation. Residents have been informed as appropriate. Following a resident's allegation that a staff member has committed sexual abuse against the resident, the facility subsequently informs the resident (unless the facility has determined that the allegation is unfounded) whenever: The staff member is no longer posted within the resident's unit; The staff member is no longer employed at the facility; The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. There has been no allegations of sexual abuse committed by a staff member against a resident in the facility in the past 12 months. Following a resident's allegation that he or she has been sexually abused by another resident in an agency facility, the agency subsequently informs the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or the agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. The agency has a policy that all notifications to residents described under this standard are documented.

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.

Facility staff are subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. In the past 12 months no staff from the facility was alleged to have violated agency sexual abuse or sexual harassment policies. Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. In the past 12 months, there have been no staff from the facility that have been reported to law enforcement or licensing boards following their termination (or resignation prior to termination) for violating agency sexual abuse or sexual harassment policies.

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.

Agency policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. Agency policy requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. In the past 12 months, no contractors or volunteers have been reported to law enforcement agencies and relevant licensing bodies for engaging in sexual abuse of residents. The facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

Standard 115.378 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy review and interviews indicate: Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse. Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following a criminal finding of guilt for resident-on-resident sexual abuse. In the past 12 months there have been one finding of resident-on-resident sexual abuse that have occurred at the facility. In the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, residents in isolation receive daily visits from a medical or mental health care clinician. In the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, residents in isolation have access to other programs and work opportunities to the extent possible. In the past 12 months no residents have been placed in isolation as a disciplinary sanction for resident-on resident sexual abuse. The facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse and considers whether to require the offending resident to participate in such interventions as a condition of access to any rewards-based behavior management system or other behavior based incentives. Access to general programming or education is not conditional on participation in such interventions. The agency disciplines residents for sexual contact with staff only upon finding that the staff member did not consent to such contact.The Agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation. The agency prohibits all sexual activity between residents and disciplines residents for such activity, but deems such activity to constitute sexual abuse only if it determines that the activity is coerced.

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.

All residents at this facility who have disclosed any prior sexual victimization during a screening pursuant to ß115.341 are offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. In the past 12 months, all residents regardless of disclosure for prior victimization during screening who were offered a follow up meeting with a medical or mental health practitioner. Medical and mental health staff maintain secondary materials documenting compliance with the above required services. All residents who have previously perpetrated sexual abuse, as indicated during the screening pursuant to ß 115.341, are offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening. Mental health staff maintain secondary materials documenting compliance with the above required services. The information shared with other staff is strictly limited to informing security and management decisions, including treatment plans, housing, bed, work, education, and program assignments, or as otherwise required by federal, state, or local law. In excess of PREA Standards requiring a referral within 14 days, a new resident usually sees a mental health practitioner right away as part of the standard screening processes. Doubling down, page 87 of policy in place since Jan. 1, 2015, dictates that " . . . the resident must be referred to a mental health provider or a licensed physician within 48 hours of the recommendation."

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.

Resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. Medical and mental health staff maintain secondary materials documenting the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning sexually transmitted infection prophylaxis. All residents are offered pregnancy tests when applicable and given information about medical services. Treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

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.

The facility offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. Resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate. Treatment services are provided 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. The facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days (Webb County requires this usually be completed within 48 hours) of learning of such abuse history and offers treatment when deemed appropriate by mental health practitioners. In excess of PREA

standards, the facility maintains an updated Health Service Plan and employs a Health Services Coordinator, and has had this procedure in place since before 2015 (See page 51 of the Revised Chapter 343 of the Agency Policies effective Jan. 1, 2015). The mandated Health Services Coordinator oversees a variety of health needs, including some related directed or indirectly to sexual abuse. Section 343.330 (Page 62) of the 2015 policy [the policy has had recent updates but the older policy is quoted here to show, along with interviews, that the facility has exceeded standards for more than 12 months] states, "Medical Treatment for Victims of Abuse: A. Testing for sexually-transmitted diseases, including HIV/AIDS, shall be made available to a resident who is found in an internal or TJJD investigation, to have been abused, neglected, or exploited in a manner by which any physical injuries or any sexually-transmitted disease may have been contracted. B. Testing and any subsequent medical treatment shall be at no cost to the resident or his/her family. C. Appropriate testing and treatment services shall be made by or in direct consultation with a health care professional. Section 343.332 – Behavioral Health Care Services for Sexual Abuse Victims: A. Any resident found to be a victim of abuse, neglect, or exploitation that occurred in the facility, following an internal or TJJD investigation, shall be assessed by a mental health provider. The mental health provider shall assess: 1. the need for crisis intervention counseling; 2. any subsequent long-term, follow-up, or counseling services. B. Any of the above services shall be at no cost to the resident or his/her family. C. Appropriate assessment and counseling services shall be made by or in direct consultation with a mental health provider."

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.

The facility conducts a sexual abuse incident review at the conclusion of every sexual abuse criminal or administrative investigation, unless the allegation has been determined to be unfounded. The facility conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation. The sexual abuse incident review team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners. The review team considers whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; considers 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 dynamics at the facility; examines the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; assesses the adequacy of staffing levels in that area during different shifts; assesses whether monitoring technology should be deployed or augmented to supplement supervision by staff; and prepares a report of its findings, including but not necessarily limited to determinations made pursuant to this section, and any recommendations for improvement, and submits such report to the facility head and PREA compliance manager. The facility implements the recommendations for improvement, or documents its reasons for not doing so.

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.

The agency collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The standardized instrument includes, 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. The agency aggregates the incident-based sexual abuse data at least annually. The facility maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. The agency obtains incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents. The agency can provide the Department of Justice with data from the previous calendar year upon request.

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.

The Agency reviews data collected and aggregated pursuant to ß115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training, including: Identifying problem areas; Taking corrective action on an ongoing basis; and Preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the agency as a whole. The annual report includes a comparison of the current year's data and corrective actions with those from prior years. Annual reports provide an assessment of the agency's progress in addressing sexual abuse. The agency makes its annual report readily available to the public at least annually through its website and through other means. The annual reports are approved by the agency head. When the agency redacts material from an annual report for publication the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility. The report also reiterates the State's commitment to the integrity of this process.

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.

The facility ensures that incident-based and aggregate data are securely retained. Agency policy requires that aggregated sexual abuse data be made readily available to the public, at least annually, through the agency. Before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers. The agency maintains sexual abuse data collected pursuant to ß115.387 for at least 10 years after the date of initial collection, unless Federal, State or local law requires otherwise. Interviews with administrators who explained their system and also verified a broad commitment to confidentiality that is reflected in their written agency policy, indicate this standard is being followed to the best of their ability and understanding.

AUDITOR CERTIFICATION

I certify that:

- ☒ The contents of this report are accurate to the best of my knowledge.
- ☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- ☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

D. Will Weir — 09/08/2016

Auditor Signature — Date