Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Report 07/29/2019

Auditor Information

Name: Joel T. Whitt	**Email:** joel.whitt@zajonc-corp.com
Company Name: Zajonc	
Mailing Address: PO Box 10751	**City, State, Zip:** College Station, Texas, 77842
Telephone: 210-744-4943	**Date of Facility Visit:** July 17, 2019

Agency Information

Name of Agency Hays County Juvenile Center	**Governing Authority or Parent Agency** *(If Applicable)* Click or tap here to enter text.
Physical Address: 2250 Clovis Barker Road	**City, State, Zip:** San Marcos, Texas, 78666
Mailing Address: 2250 Clovis Barker Road	**City, State, Zip:** San Marcos, Texas, 78666

The Agency Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☒ County	☐ State	☐ Federal

Agency Website with PREA Information: Click or tap here to enter text.

Agency Chief Executive Officer

Name: Brett Littlejohn	
Email: brett.littlejohn@co.hays.tx.us	**Telephone:** 512-393-7625

Agency-Wide PREA Coordinator

Name: Brett Littlejohn	
Email: brett.littlejohn@co.hays.tx.us	**Telephone:** 512-393-7625
PREA Coordinator Reports to: Hays County Juvenile Board	**Number of Compliance Managers who report to the PREA Coordinator:** 1

Facility Information

Name of Facility: Hays County Juvenile Center			
Physical Address: 2250 Clovis Barker Road		**City, State, Zip:** San Marcos, Texas, 78666	
Mailing Address (if different from above): Click or tap here to enter text.		**City, State, Zip:** Click or tap here to enter text.	
The Facility Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☒ County	☐ State	☐ Federal

Facility Website with PREA Information: https://hayscountytx.com/courts/juvenile-detention-center/documents-for-download/

Has the facility been accredited within the past 3 years? ☐ Yes ☒ No

If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years):

☐ ACA

☐ NCCHC

☐ CALEA

☐ Other (please name or describe: Click or tap here to enter text.

☒ N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:
NA

Facility Administrator/Superintendent/Director

Name: Brett Littlejohn			
Email: brett.littlejohn@co.hays.tx.us		**Telephone:** 512-393-7625	

Facility PREA Compliance Manager

Name: Burlon Parsons			
Email: Burlon.parsons@co.hays.tx.us		**Telephone:** 512-393-7625	

Facility Health Service Administrator ☐ N/A

Name: Suzanne McCutcheon			
Email: Suzanne.mccutcheon@co.hays.tx.us		**Telephone:** 512-393-7625	

Facility Characteristics	
Designated Facility Capacity:	114
Current Population of Facility:	43
Average daily population for the past 12 months:	40
Has the facility been over capacity at any point in the past 12 months?	☐ Yes ☒ No
Which population(s) does the facility hold?	☐ Females ☐ Males ☒ Both Females and Males
Age range of population:	10-17
Average length of stay or time under supervision	31 days
Facility security levels/resident custody levels	secure

Number of residents admitted to facility during the past 12 months	459
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:	169
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *10 days or more:*	358
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	☐ Yes ☒ No

Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	☐ Federal Bureau of Prisons ☐ U.S. Marshals Service ☐ U.S. Immigration and Customs Enforcement ☐ Bureau of Indian Affairs ☐ U.S. Military branch ☐ State or Territorial correctional agency ☒ County correctional or detention agency ☒ Judicial district correctional or detention facility ☐ City or municipal correctional or detention facility (e.g. police lockup or city jail) ☐ Private corrections or detention provider ☐ Other - please name or describe: Click or tap here to enter text. ☐ N/A

Number of staff currently employed by the facility who may have contact with residents:	78
Number of staff hired by the facility during the past 12 months who may have contact with residents:	26

Number of contracts in the past 12 months for services with contractors who may have contact with residents:	9
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	9
Number of volunteers who have contact with residents, currently authorized to enter the facility:	6
Physical Plant	
Number of buildings: **Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.**	2
Number of resident housing units: **Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.**	1
Number of single resident cells, rooms, or other enclosures:	30
Number of multiple occupancy cells, rooms, or other enclosures:	5
Number of open bay/dorm housing units:	5
Number of segregation or isolation cells or rooms (for example, administrative, disciplinary, protective custody, etc.):	2
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	☒ Yes ☐ No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	☐ Yes ☒ No

Medical and Mental Health Services and Forensic Medical Exams	
Are medical services provided on-site?	☒ Yes ☐ No
Are mental health services provided on-site?	☒ Yes ☐ No
Where are sexual assault forensic medical exams provided? Select all that apply.	☐ On-site ☒ Local hospital/clinic ☒ Rape Crisis Center ☐ Other (please name or describe: Click or tap here to enter text.)

Investigations	
Criminal Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:	Click or tap here to enter text.
When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.	☐ Facility investigators ☐ Agency investigators ☒ An external investigative entity
Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)	☒ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: Click or tap here to enter text.) ☐ N/A
Administrative Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	2
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply	☒ Facility investigators ☒ Agency investigators ☐ An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	☐ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: Click or tap here to enter text.) ☒ N/A

Audit Findings

Audit Narrative

The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-onsite audit, onsite audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.

The Pre-Onsite Audit began on May 3, 2019. Photographic evidence of the required notice was received on May 3, 2019 of the posting throughout the facility. During the Pre-Audit process there were multiple electronic contacts between the Agency Head/PREA Coordinator and this auditor. These contacts included discussion of the on-line audit system. HCJC planned on utilizing the On-Line Audit system but provided this auditor with all PRE-Audit information electronically due to delays in the set-up of the On-Line Audit System access due to access approval required by a County Judge who was unavailable. As a result, the On-Line Audit System was not accessible and was not used as planned. All PRE-Audit Information was received by the auditor on May 20th, 2019 and a conference call was held on June 5th with the PREA Coordinator and PREA Compliance Manager in preparation for the on-site portion of the audit. On June 6th an On-Site Schedule and On-Site data required was provided to the Agency Head/PREA Coordinator.

The On-Site Audit began on June 17, 2019 and ended on June 19, 2019. On the first day of the onsite auditing an introduction meeting was held at approximately 9:00AM with various facility administrators (three total HCJC staff) including the PREA Coordinator and PREA Compliance Manager. Following this meeting, a tour of the facility was conducted, and this Auditor noted the location of the 64 security cameras throughout the facility, the physical grounds and the structures. Further, during the tour this Auditor interviewed staff and residents. Notification of the PREA Audit, as well as, notices regarding the rights of the residents to be free from sexual abuse and sexual harassment were observed throughout the facility in resident areas. These notices included information on how residents could report sexual abuse and sexual harassment and these notices were in the predominate languages for the area: (1) English, and (2) Spanish. It was identified that residents had access to Grievance Forms in residential and educational areas. During the tour it was noted that there were areas of the facility's video monitoring system was in all resident areas. Residents or staff leaving the camera's view would be captured and recorded. Video footage for all cameras are stored for 21 days. It was also noted that there were no cameras in the residents' shower/toileting areas. Review of the camera views in the Control Room and interviews with staff and residents indicated that the cameras did not view the toilets or shower areas where residents shower, change clothes, and perform bodily functions.

On the first day of the PREA audit there were a total of 46 residents assigned to the facility. While touring the facility, this Auditor observed residents being supervised by HCJC Juvenile Supervisions Officers (i.e., security staff) and teaching staff.

This Auditor interviewed 10 randomly selected residents and 1 resident targeted for specialized interviews at the facility as part of the PREA Audit due to reporting past sexual abuse during their risk screening. Residents were selected form each area of the facility (single cells and Residents reported being informed of the facility's Zero-Tolerance Policy related to sexual abuse and sexual harassment and their right to be free from sexual abuse and sexual harassment as well as their right to be free from retaliation for reporting sexual abuse and/or sexual harassment. Eleven (11) of the 11 residents, or 100%, indicated that they received their PREA Information at their time of intake. All residents reported that they received their PREA Education within 10 days of intake. A later review of 21 randomly-selected files noted that 21 out of 21

current residents (100%) did receive PREA information at their time of intake and all had the required documentation supporting the fact that the residents received their PREA Education within the 10-day timeline. Residents reported receiving the PREA Education one a per month while at the facility in addition to the initial information and education.

During the onsite audit this Auditor talked to security staff, counselors, volunteers, and intake staff. In all, during the onsite audit a total of 15 staff (including employees, volunteers and contractors) were interviewed. Ten (10) of these staff were randomly selected from all shifts and five (5) were specialized staff. Overall, the staff interviews revealed that staff felt that they had been trained in the PREA standards, their obligations as first-responders, and their respective responsibilities and duties to prevent, detect, and respond to sexual abuse, sexual harassment, and allegations of retaliation for reporting sexual abuse and sexual harassment. The intake staff noted that they have completed a risk factor analysis for each resident to determine proper room and programmatic assignments. This auditor found that the risk factor assessment included all the required elements as per PREA utilizing a questionnaire at intake and the completion of the MAISI Assessment. Review of resident files found three residents who had reported either sexual abuse or committing an act of sexual abuse. Evidence indicates all youth see a counselor within their first week. Of the three residents one only one had been in the facility for more than two weeks. Interviews with the counseling staff found that the youth had been provided counseling within two weeks of intake and that the need for services regarding the reported abuse was addressed; the facility had created a referral process from intake to mental health for youth responded to past history of sexual abuse or sexually abusive behaviors or offenses.

Contact between this auditor and the facility continued after the On-Site. On July 23, 2019 this auditor returned to the facility to review new intakes of residents reporting past sexual abuse or sexual aggressive behavior or charges. There were three new intakes that met this criteria; 2 reporting past sexual abuse and 1 reporting charges of sexual assault as the perpetrator. Review of the new referral process at intake found documentation that indicated that the process was effectively utilized furthering the conclusion of compliance in this area.

Facility Characteristics

The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate, resident or detainee population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

Hays County Juvenile Center (HCJC) is a secure detention facility located within the City of San Marcos, Hays County, Texas. The facility is located at 2250 Clovis Barker Road, San Marcos, Texas 78666. The mission of the HCJC is to provide residents an opportunity to succeed in a safe, secure and structured environment. The Agency and Facility Head is Brett Littlejohn, Mr. Littlejohn serves as the PREA Coordinator for the facility. Burlon Parsons is the Assistant Facility Administrator and serves as the PREA Compliance Manager.

The HCJC is a 42,000-square-foot secure facility. The designed capacity is 114 residents ages 10 to 17. At the time of the on-site there were a total of 46 residents in the facility. In the past 12 months there have been 459 resident intakes to the facility. Only 169 of these youth remained in the facility longer than 10 days. The average length of stay is 31 days. The facility has 78 employees who have contact with residents and of these, 26 have been hired in the past 12 months.

The Facility consists of 2 secure buildings and 1 non-secure. The facility has a total of 30 single cell housing units. Single cell units are used for short-term detention residents. The facility has 5 open bay housing units that are utilized for long-term residents who have been screened and identified as appropriate for the long-term program. The facility houses both male and female residents; however, these residents are separated and have no interaction. The facility has two segregation cells for administrative or disciplinary purposes. The facility consists of a Central Control Room that continuously monitors residents and staff via 64 video cameras that record and preserve these recordings for 21 days. The facility has an open visitation area and a secure visitation area, nurse's station/exam room, educational classrooms, indoor recreation/gymnasium, business and counseling offices, and a cafeteria. All areas that residents are allowed to enter are covered by the video monitoring system; except those areas where residents change, shower, undress, or perform bodily functions.

Medical care services onsite include a basic health screening. Residents with medical needs are referred out to the appropriate care in the community. Forensic Sexual Assault Exams are completed at the Central Texas Medical Center. The Central Texas Medical Center has SANE Nurses on staff and on-call. The HCJC has a Memorandum of Agreement with the Hays-Caldwell Women's Center/Roxanne's House a Rape Crisis Center for advocacy and victim's services. HCJC has a Memorandum of Agreement with the San Marcos Police Department for criminal investigations. HCJC completes its own administrative investigations and has trained investigators that achieve compliance with standards. HCJC has not had an allegation of sexual abuse or sexual harassment in the past 12 months; and as a result, there have been no forensic medical exams, criminal investigations, or SANE exams in the past 12 months.

Summary of Audit Findings

The summary should include the number and list of standards exceeded, number of standards met, and number and list of standards not met.

Auditor Note: *No standard should be found to be "Not Applicable" or "NA". A compliance determination must be made for each standard.*

Standards Exceeded

Number of Standards Exceeded: 0
List of Standards Exceeded: NA

Standards Met

Number of Standards Met: 41

Standards Not Met

Number of Standards Not Met: 0
List of Standards Not Met: NA

PREVENTION PLANNING

Standard 115.311: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

All Yes/No Questions Must Be Answered by The Auditor to Complete the Report

115.311 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☐ Yes ☐ No

115.311 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities? ☒ Yes ☐ No

115.311 (c)

- If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.) ☐ Yes ☐ No ☒ NA
- Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC PREA Policy 115.311 – Pages 10-13
2. Agency and Facility Organizational Chart
3. Interviews with the following:
a. PREA Coordinator
b. PREA Compliance Manager
c. Facility Head
d. 10 facility random resident and 1 specialized resident interviews
e. Interviews with 10 Security Staff
f. Interviews with Specialized Staff (1 First Responder, 1 PREA Incident Review Team Member, 1 Mental Health Provider, 1 Investigator, 1 Human Resource Manager, 1 Contractor, 1 Volunteer, and 1 Education Staff Member)
4. Training Records
5. Pre-Audit Questionnaire

Findings (By Subsection):

Subsection (a):

The Agency has a comprehensive policy on sexual abuse and sexual harassment contained throughout the HCJC Policy113.115 Pages 10-13. The policy clearly mandates zero tolerance toward all forms of sexual abuse and sexual harassment and outlines the Agency's approach to preventing, detecting and responding to any allegation of sexual abuse or sexual harassment or suspicion of sexual abuse or sexual harassment. The HCJC Policy details definitions that are compliant with the PREA definitions on pages 8-9. The Policy 113.115 further outlines the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment.

Subsection (b):

The Agency has designated the Brett Littlejohn as the PREA Coordinator. Mr. Littlejohn is housed at the single facility. Mr. Littlejohn is the Agency and Facility Head and his Supervisor the Agency Head. Interviews with Mr. Littlejohn and the Organizational Chart indicate that he has sufficient time and authority to develop, implement, and overseen agency efforts to comply with PREA Standards.

Subsection (c):

The Agency has a single Facility. Both the PREA Coordinator and PREA Compliance Manager are located within the Facility. Verification of the PAQ onsite and evidence reviewed including Facility, Interviews, and Policy each indicate compliance.

Standard 115.312: Contracting with other entities for the confinement of residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.312 (a)

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to adopt and comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☐ Yes ☐ No ☒ NA

115.312 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. Interviews
a. Agency Head
b. PREA Coordinator
c. PREA Compliance Manager
2. Pre-Audit Questionnaire
3. HCJC Policy page 14

Subsection (a):

The Agency is not licensed or authorized by the State of Texas to act as a child placing agent and is not able to contact for the confinement or placement of residents at another facility. Verification of compliance was determined through interviews with the Agency Head, PREA Coordinator, and PREA Compliance Manager. It was determined that the Facility does not contact with other entities for the confinement of residents and is compliant with standard.

Subsection (b):

The Agency is not licensed or authorized by the State of Texas to act as a child placing agent and is not able to contact for the confinement or placement of residents at another facility. Verification of compliance was determined through interviews with the Agency Head, PREA Coordinator, and PREA Compliance Manager. It was determined that the Facility does not contact with other entities for the confinement of residents and is compliant with standard.

Standard 115.313: Supervision and monitoring

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.313 (a)

- Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?
- ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Generally accepted juvenile detention and correctional/secure residential practices? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any judicial findings of inadequacy? ☐ Yes ☒ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from Federal investigative agencies? ☐ Yes ☒ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from internal or external oversight bodies? ☐ Yes ☒ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The number and placement of supervisory staff? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Institution programs occurring on a particular shift? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any applicable State or local laws, regulations, or standards? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors? ☒ Yes ☐ No

115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? ☒ Yes ☐ No

- In circumstances where the staffing plan is not complied with, does the facility document all deviations from the plan? (N/A if no deviations from staffing plan.) ☒ Yes ☐ No ☐ NA

115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.)
  ☒ Yes ☐ No ☐ NA

- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) ☒ Yes ☐ No ☐ NA

- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) ☒ Yes ☐ No ☐ NA

- Does the facility ensure only security staff are included when calculating these ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) ☒ Yes ☐ No ☐ NA

- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? ☒ Yes ☐ No

115.313 (d)

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan? ☒ Yes ☐ No

115.313 (e)

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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 Staffing Plan
2. Facility schematics and diagrams of physical plant layout
3. HCJC Policy 115.313 pages 15-20
4. Unannounced Rounds – Unannounced Round Log Maintained by the PREA Compliance Manager.
5. Interviews with the following:
a. PREA Coordinator
b. PREA Compliance Manager
c. Agency Head
6. On-site review of housing areas and program areas of facility (Intake Area, Resident Day Areas, Kitchen, Dinning, Storage Areas, Education, Mental Health/Case Management, and Administrative.)
7. Review of video footage verifying the completion of unannounced rounds.
8. Pre-Audit Questionnaire

Findings (By Subsection):

Subsection (a):

The HCJC facility is a secure facility. The facility maintains a ratio compliant to the standard. The facility has mandatory overtime for staff as needed to ensure compliance is maintained. Review of the staffing plan and interviews with Agency Head and PREA Coordinator indicated that the staffing plan is developed annually and includes the key factors pursuant to standard.

Subsection (b):

The HCJC facility is a secure facility. The facility maintains a ratio compliant to the standard. The facility has mandatory overtime for staff as needed to ensure compliance is maintained. Review of the staffing plan and interviews with Agency Head and PREA Coordinator indicated that the staffing plan is developed annually and includes the key factors pursuant to standard. The facility maintains documentation of deviations.

Subsection (c):

The HCJC facility is a secure facility. The facility maintains a ratio compliant to the standard. The facility has mandatory overtime for staff as needed to ensure compliance is maintained. Review of the Staffing Plan, deviation reports, and interviews with the PREA Coordinator, PREA Compliance Manager and staff indicate compliance with standard.

Subsection (d):

The Staffing Plan is currently reviewed and signed by the PREA Coordinator annually. Interviews indicate that annually the Staffing Plan is established, prevailing staff patterns are reviewed, consideration of video monitoring is on-going, and there is an on-going review of resources available to commit to ensure adherence to the staffing plan.

Subsection (e):

HCJC Policy requires intermediate-level and higher level supervisors conduct unannounced rounds at least monthly on all shifts. The facility maintained documentation of these rounds and review of video files showed that these rounds occurred as reported. The Policy also prohibits staff from alerting other

staff that rounds are occurring. Both the PREA Coordinator and PREA Compliance Manager reported that this was practice and prohibited.

Standard 115.315: Limits to cross-gender viewing and searches

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.315 (a)

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?
  ☒ Yes ☐ No

115.315 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances? ☒ Yes ☐ No ☐ NA

115.315 (c)

- Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches? ☒ Yes ☐ No

- Does the facility document all cross-gender pat-down searches? ☒ Yes ☐ No

115.315 (d)

- Does the facility have policies that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No

- Does the facility have procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No

- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? ☒ Yes ☐ No

- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units) ☒ Yes ☐ No ☐ NA

115.315 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? ☒ Yes ☐ No

- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? ☒ Yes ☐ No

115.315 (f)

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC PREA Policy and Procedures pages 20-23
2. Interviews with the following:
a. 10 Random Staff
b. 11 Random Residents
c. Facility Head
3. Tour of Facility

Findings (By Subsection):
Subsection (a):

HCJC PREA Policy and Procedures pages 20-21 indicate that Cross-gender strip searches or cross-gender visual body cavity searches are not permitted except in exigent circumstances or when performed by medical practitioners as part of their duties. Interviews with staff and residents found that the policy was enforced, and cross gender searches are prohibited.

Subsection (b):

HCJC PREA Policy and Procedures pages 21-22 indicate that cross-gender pat-down searches are not permitted except in exigent circumstance. Interviews with security staff and residents indicated that cross-gender pat-down searches are prohibited, and none had witnessed or completed a cross-gender pat-down search.

Subsection (c):

HCJC PREA Policy and Procedures pages 21-22 indicate that all cross-gender searches are not permitted except in exigent circumstance. Interviews with security staff and residents indicated that cross-gender pat-down searches are prohibited, and none had witnessed or completed a cross-gender strip search, a cross gender visual body cavity search, or a cross-gender pat-down search. In exigent circumstances that result in a cross-gender strip, visual body-cavity, or pat-down search, a Serious Incident Report is required. The report requires:

a. Identifying the staff who conducted the search;
b. If that staff was a medical practitioner;
c. Gender of the staff;
d. Gender of the individual searched; and
e. Explanation of the exigent circumstances that required the cross-gender search.

Subsection (d):

Policy 115.315 page 21-22 indicate all residents are able to shower perform bodily functions and change clothes without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia. Interviews with residents and staff verified this was the practice at the facility.

Subsection (e):

HCJC Policy 115.315 page 22 prohibits searches or physical examinations of a transgender or intersex resident for the sole purpose of determining the resident's genital status. Interviews with staff indicate they have been trained and are knowledgeable on this policy and they do not conduct these type searches. The evidence reviewed included the Policy and Interviews; each provided evidence of compliance with this subsection.

Subsection (f):

Agency Staff Training and Orientation Requirements requires residential/security staff to be trained on how to conduct searches of residents including transgender and intersex residents before working with residents. The evidence reviewed included the Policy, Training Records, and Interviews; each provided evidence of compliance with this subsection.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.316 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an 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, including: Residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an 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, including: Residents who are blind or have low vision? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an 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, including: Residents who have intellectual disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an 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, including: Residents who have psychiatric disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an 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, including: Residents who have speech disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an 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, including: Other? (if "other," please explain in overall determination notes.) ☒ Yes ☐ No

- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

115.316 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? ☒ Yes ☐ No

- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

115.316 (c)

- Does the agency always refrain from relying on 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 §115.364, or the investigation of the resident's allegations? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.316 page 23-26
2. Interviews with the following:
a. Agency Head

b. PREA Coordinator
c. PREA Compliance Manager
d. Random Staff

Findings (By Subsection):

Subsection (a):

HCJC Policy pages 23-26 ensures that disabled residents; including those who are deaf/hard of hearing or those that are blind or visually impaired, and those who have intellectual, psychiatric, or speech disabilities, have equal access to all aspects of the facility's PREA protections. The Agency has made provisions for all disabled youth through established relationships within the community, Special Education Staff, and educational materials to fit the need of the resident. The evidence reviewed included the Policy, viewing of posters, and Interviews; each provided evidence of compliance with this subsection.

Subsection (b):

HCJC Policy pages 23-26 ensures that residents who are limited English proficient (LEP) have access to all aspects of the facility's PREA protections. Posters were identified in resident areas stating the zero tolerance for sexual abuse and harassment and mechanisms for reporting in both English and Spanish. Both the Agency and Facility Staff indicate that there are staff who are Bi-Lingual (English and Spanish) and that as necessary the Agency would provide access to interpreters if staff were unable to meet the resident's needs. It was indicated that LEP students were infrequent but translators who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary will be secured if resources are not immediately available. The evidence reviewed included the Policy and Interviews; each provided evidence of compliance with this subsection.

Subsection (c):

HCJC Policy pages 23-26 indicates that the Agency does not use of resident interpreters, resident readers, or other types of resident assistants except in limited circumstances as authorized by this standard. Interviews with staff members consistently revealed that resident interpreters are never used, and staff could articulate why using resident interpreters is not considered a best practice. Staff interviews indicate there are staff who are Bi-Lingual (English and Spanish) who are also available for translator services and that the Agency would provide translator services as needed if existing resources were inadequate. The evidence reviewed included the Policy and Interviews; each provided evidence of compliance with this subsection.

Standard 115.317: Hiring and promotion decisions

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.317 (a)

- Does the agency prohibit the hiring or promotion of anyone 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)? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: 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? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of 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)? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: 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? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

115.317 (b)

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone who may have contact with residents? ☒ Yes ☐ No

- Does the agency consider any incidents of sexual harassment in determining whether to enlist the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.317 (c)

- Before hiring new employees, who may have contact with residents, does the agency perform a criminal background records check? ☒ Yes ☐ No

- Before hiring new employees, who may have contact with residents, does the agency consult any child abuse registry maintained by the State or locality in which the employee would work? ☒ Yes ☐ No

- Before hiring new employees who may have contact with residents, does the agency, consistent with Federal, State, and local law, make 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? ☒ Yes ☐ No

115.317 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

- Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.317 (e)

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees? ☒ Yes ☐ No

115.317 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? ☒ Yes ☐ No

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? ☒ Yes ☐ No

- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? ☒ Yes ☐ No

115.317 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? ☒ Yes ☐ No

115.317 (h)

- Does the agency 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? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.317 pages 26-29
2. Employment Application Form (as of date of on-site audit)
3. Professional Reference Check Form
4. Personnel Files for Existing Staff (19 reviewed onsite)
5. Interviews with the following:
a. Administrative (Human Resources) Staff
b. PREA Coordinator
c. Volunteer

Findings (By Subsection):

Subsection (a):

HCJC Policy Pages 26-29 provides the disqualifications from employment and promotion with the agency and the prohibition tracks this PREA standard. Evidence that this information was viewed onsite in employee files. The Agency requires the needed background checks for volunteers and contractors. Self-disclosure is included in the signed contracts reviewed onsite and volunteer applications. The evidence reviewed included the Policies Form Review, File Review and Interviews; each provided evidence of compliance.

Subsection (b):

HCJC Policy Pages 26-29 and interviews performed on site indicate that the agency takes into consideration any incidents of sexual harassment in determining whether to hire or promote an applicant. The evidence reviewed included Policy, File Review and Interviews; each provided evidence of compliance with this subsection.

Subsection (c):

HCJC Policy Pages 26-29 contains the requirements for the performance of background checks, consultation with the child abuse registry maintained by the Texas Department of Family and Protective Services, and commitment to best effort to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of sexual abuse. Policy requires criminal history checks from the Texas Crime Information Center (TCIC) and the National Crime Information Center (NCIC). Additionally, applicants must have checks in the Fingerprint Applicant Services of Texas (FAST) and the Fingerprint-based Applicant Clearinghouse of Texas (FACT) through the Texas Department of Public Safety. Checks must be received prior to employment. Additionally, policy requires the Agency to consult the local child abuse registry and the child abuse

registry of any state where the applicant has resided in the last 10 years. The Auditor reviewed personnel files for new hires and the documentation showed that the required checks are being conducted. All employees, contractors, volunteers and interns are entered into the system and rechecked every two years. FAST provides immediate reports to Agency and Facility Head of any arrests or violations. The Facility also utilizes the Texas Department of Family and Protective Services Registry Check and the Texas Juvenile Justice Department's system which monitor all institutional investigations in the state to prevent employees from leaving in mid-investigation and seeking employment at another facility. The evidence reviewed included the Policies Form Review, File Review and Interviews; each provided evidence of compliance with this subsection.

Subsection (d):

HCJC Policy pages 26-29 requires that a criminal background check and DFPS child abuse registry check be completed on all contractors prior to enlisting their services. Review of contractor files indicated compliance with this policy and subsection.

Subsection (e):

Facility maintains and active subscription to the FAST System and all employees, contractors, volunteers and interns are entered into the system and rechecked every two years. FAST provides immediate reports to Agency and Facility Head of any arrests or violations. The Facility also utilizes the Texas Department of Family and Protective Services Registry Check and the Texas Juvenile Justice Department's system which monitor all institutional investigations in the state to prevent employees from leaving in mid-investigation and seeking employment at another facility. The evidence reviewed included the Policies Form Review, File Review and Interviews; each provided evidence of compliance with this subsection. Documentation indicated that background checks are completed every two years; 100% of files reviewed indicated this had occurred. Based on the evidence reviewed compliance with this subsection was determined.

Subsection (f):

Interviews and file review indicated that new hires were asked about previous misconduct as described in paragraph a; interviews and policy indicate the same process is followed for promotions. Personnel file review indicated this policy was implemented and compliance with subsection was determined.

Subsection (g):

HCJC Policy states that omissions regarding misconduct identified in subsection a shall be grounds for termination of employment. Interviews with the PREA Coordinator and the Agency Head indicated that this was accurate and the presumptive disciplinary action. Based on the evidence reviewed compliance with subsection was determined.

Subsection (h):

HCJC Policy pages 26-29 indicates that unless prohibited by law HCJC provides information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer. Interviews with the PREA Coordinator, Human Resource Director, and Agency Head supported this policy. The evidence provided supported compliance with subsection.

Standard 115.318: Upgrades to facilities and technologies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.318 (a)

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☐ Yes ☐ No ☒ NA

115.318 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. Interviews with the following:
a. Agency Head
b. PREA Compliance Manager
c. PREA Coordinator
2. Site Review and Tour of Building and Infrastructure (interior and exterior).

3. Review of camera placement (cameras are not operational and are not in restrooms, showers or resident living facilities).
4. HCJC Policy 115.318 pages 30-31

Findings (By Subsection):

Subsection (a):

There have been no substantial expansions or modifications of existing facilities since 2016.

Subsection (b):

HCJC utilizes a video surveillance system. Staff interviews indicate that the video monitoring system does enhance the agency's ability to protect residents from sexual abuse. Interviews with the PREA Coordinator and PREA Compliance Manager indicated that some upgrades to the system have been completed during the past year; however, these upgrades did not alter the use of the system and were simple enhancements to replace older components.

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.321 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice'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? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? ☒ Yes ☐ No

- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No

- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? ☒ Yes ☐ No

- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

115.321 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? ☒ Yes ☐ No

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? (N/A if the agency *always* makes a victim advocate from a rape crisis center available to victims.) ☒ Yes ☐ No ☐ NA

- Has the agency documented its efforts to secure services from rape crisis centers? ☒ Yes ☐ No

115.321 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? ☒ Yes ☐ No

- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? ☒ Yes ☐ No

115.321 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating agency follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.321 pages 31-35
2. Interviews with the following:
    a. Random Staff
    b. PREA Compliance Manager
    c. PREA Coordinator
3. Contact and Verification with the Central Texas Medical Center that has Sexual Assault Nurse Examiners on call in the event that a sexual assault victim presents at the Emergency Room.
5. Memorandum of Understanding between the Agency and the Hays-Caldwell Women's Center Roxanne's House (HCWC)
6. Memorandum of Understanding between the Agency and the San Marcos Police Department
7. Sexual Abuse First Responders Protocol – Agency's Coordinated Response Plan
8. Investigator Training Records
9. Agency Website - https://hayscountytx.com/wpfb-file/prea-policy-and-procedure-docx/

Findings (By Subsection):

Subsection (a):

The Agency conducts administrative investigations on all allegations of sexual abuse. HCJC Policy 115.321 pages 31-35states the protocols used are adapted from the national protocol referenced in this standard. Staff interviews found that all security staff were able to describe how protocols to maximize the potential for obtaining usable physical evidence for administrative proceedings and proceedings and criminal prosecutions following practices adapted from the National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents. Staff training records supported that staff were trained to follow these protocols.

Subsection (b):

The protocol used by the Agency is adapted from the *National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents*.

Subsection (c):

According to Agency Policy and the Coordinated Response Plan, a victim of sexual abuse at the facility will receive SAFE/SANE services in San Marcos. Documentation was provided that both the Police Department and hospital were requested to utilize protocols compliant with standard. Contact with the hospital confirmed that there was always a SANE Nurse on call and in their absence an MD and RN would utilize the standard forensic kit and protocols. SANE services are provided to a victim without financial cost pursuant to HCJC Policy.

Subsection (d):

The Agency has a memorandum of understanding with HCWC. HCWC will provide victim advocacy services to victims of sexual abuse at the Facility. Pursuant to the written Coordinated Response Plan HCWC is contacted upon request of a victim of an allegation of sexual assault.

Subsection (e):

Pursuant to the terms of the MOU, the HCWC advocate will accompany and support the victim through the forensic medical exam process and the investigatory interviews, etc. This information is located on the Agency's Website and provided to youth during orientation and education in writing. The Auditor contacted the HCWC to verify advocacy services and protocols utilized; verification that the hotline was operational was also made.

Subsection (f):

The Agency has requested that local law enforcement utilize the national protocol and follow the requirements of this standard. At the time of the onsite audit and this report a response had not been received formally; however, the Police Department has indicated its investigators have been trained on protocols compliant with the standard. The Agency should obtain this response in writing with on-going follow-up.

Subsection (h):

Agency Policy and MOU establish that the Rape Crisis Center is always made available to residents.

Standard 115.322: Policies to ensure referrals of allegations for investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.322 (a)

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? ☒ Yes ☐ No

115.322 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No

- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No

- Does the agency document all such referrals? ☒ Yes ☐ No

115.322 (c)

- If a separate entity is responsible for conducting criminal investigations, does the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for criminal investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.322 pages 35-39
2. Texas Family Code Chapter 261 *(Investigation of Report of Child Abuse or Neglect)*
3. Interviews with the following:
a. Agency Head,
b. Investigative Staff and
c. PREA Coordinator.
4. HCJC Policy has been published on their Website at: https://hayscountytx.com/wpfb-file/prea-policy-and-procedure-docx/

Findings (By Subsection):

Subsection (a):
HCJC Policy 115.322 pages 35-39 requires that staff administratively investigate promptly, thoroughly and objectively all allegations of sexual abuse, sexual harassment and retaliation. All conduct that may be criminal is referred to the San Marcos Police Department. Interviews with the Agency Head and Investigative Staff confirm that investigations and referrals to outside entities would occur. At the time of the on-site there had been no allegations since the previous audit.

Subsection (b):

HCJC Policy 115.322 pages 35-39 requires the referral of allegations of sexual abuse to the appropriate law enforcement agency for investigation. Interviews with the PREA Coordinator and Agency Head confirmed that the San Marcos Police Department is contacted in all allegations that may be criminal.

Subsection (c):

The San Marcos Police Department conducts all criminal investigations for conduct occurring in the Facility. This information is posted on the agency website and was verified through interviews with the Agency Head and PREA Coordinator.

TRAINING AND EDUCATION

Standard 115.331: Employee training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.331 (a)

- Does the agency train all employees who may have contact with residents on its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on how to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on the right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on the dynamics of sexual abuse and sexual harassment in juvenile facilities? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on the common reactions of juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on 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? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on how to avoid inappropriate relationships with residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on how to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on relevant laws regarding the applicable age of consent? ☒ Yes ☐ No

115.331 (b)

- Is such training tailored to the unique needs and attributes of residents of juvenile facilities? ☒ Yes ☐ No

- Is such training tailored to the gender of the residents at the employee's facility? ☒ Yes ☐ No

- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No

115.331 (c)

- Have all current employees who may have contact with residents received such training? ☒ Yes ☐ No

- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No

- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

115.331 (d)

- Does the agency document, through employee signature or electronic verification, that employees understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.331 pages 39-45
2. Interviews with the following:
    a. Random Staff
    b. PREA Compliance Manager
    c. PREA Coordinator
3. Training and Orientation Requirements/Training Records/Employee Personnel Files

Findings (By Subsection):

Subsection (a):

The Agency provided their New and Annual Employee Training Requirements/Curriculum. Both Policy and Training Requirements cover the eleven (11) mandated elements in this standard. In total, the training covers all PREA required training subjects in addition to the 11 mandated elements. This Training is provided by the PREA Coordinator or supervisory staff in person. The Facility reports in the PAQ that all staff included in the ratio have been trained on the PREA curriculum. Random staff interviews indicated that these trainings were held at least annually but there were monthly refreshers. Training records indicated this was accurate and that the new hire had received this training prior to working with residents. Evidence of training with dates was documented in each of the employee files reviewed.

Subsection (b):

The Agency's Training Records indicate that gender specific training regarding the unique needs of residents and staff; as well as gender non-conforming adolescents, is provided.

Subsection (c):

The Agency provides annual refresher training on PREA to all staff and documentation retained in the personnel files.

Subsection (d):

The Auditor reviewed the training records and found that these trainings included an employee signature indicating that they employee understood the training received.

Standard 115.332: Volunteer and contractor training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.332 (a)

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures? ☒ Yes ☐ No

115.332 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)? ☒ Yes ☐ No

115.332 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.332 pages 45-49
2. Training and Orientation Requirements/Training Records/ Volunteer, Intern, Contractual and Personnel Files
3. Interviews with the following:
a. Contractors (Mental Health)
b. Volunteer

Findings (By Subsection):

Subsection (a):

HCJC Policy requires each volunteer, intern and contractor to complete orientation training on PREA. The Agency/Facility reports in the PAQ that they have trained 7 volunteers and 6 contractors who have contact with residents.

Subsection (b):

The Agency provides orientation training to volunteers and contractors based on the services they provide and the level of contact. These individuals receive an abbreviated training based upon the general staff training. Specifically, they are training on the PREA zero tolerance policy and PREA reporting procedures. Contractors and/or volunteers with greater contact receive the full PREA Training required for staff.

Subsection (c):

The Agency maintains documentation confirming that volunteers and contractors understand the training they have received. All volunteers and contractors are required to sign a form indicating they have received and understand the Agency's zero tolerance policy regarding sexual abuse and sexual harassment and that they further understand their reporting responsibilities under PREA. File review found verification by signature that volunteers had received and acknowledged the training.

Standard 115.333: Resident education

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.333 (a)

- During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No
- Is this information presented in an age-appropriate fashion? ☒ Yes ☐ No

115.333 (b)

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No
- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No
- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.333 (c)

- Have all residents received the comprehensive education referenced in 115.333(b)? ☒ Yes ☐ No

- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility? ☒ Yes ☐ No

115.333 (d)

- Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Are deaf? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills? ☒ Yes ☐ No

115.333 (e)

- Does the agency maintain documentation of resident participation in these education sessions? ☒ Yes ☐ No

115.333 (f)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.333 pages 49-51
2. Resident Intake Form
3. Resident Orientation and Education Documentation
4. Interviews with the following:
a. Random Resident Interviews
b. Intake Staff
5. Review of Resident Files
6. Tour of housing areas and program areas of Facility; specifically observing placement of PREA information (e.g., posters, audit notices, etc.)

Findings (By Subsection):

Subsection (a):

HCJC Policy 115.333 pages 49-51 requires that all juveniles admitted into the Facility shall receive a verbal Facility orientation during admission; within their first day at the facility. Residents are provided verbal instruction of the Zero Tolerance for Sexual Abuse and Sexual Harassment Policy, What to Report, When to Report and Where to Report and that they have a right to be free from sexual abuse and sexual harassment or from retaliation from reporting in good faith. Ten of eleven residents interviewed reported receiving this information at intake; the one who stated they could not recall.

Subsection (b):

HCJC Policy 115.333 pages 49-51 requires comprehensive age appropriate education for all residents as soon as practical but within 10 days of intake. This education currently requires the residents to review material with staff, the Resident Handbook, discuss policy, rights, and reporting. Staff review the Handbook that is comprehensive and inclusive of definitions of sexual abuse and sexual harassment. Policy requires a staff member to oversee this. Residents sign off on the completion of the Education Component and that they have received and understood the handbook and information. File review of resident files found all residents had received this education on time.

Subsection (c):

All residents currently in the Facility have had PREA training. Policy and interviews indicate all residents including transfers receive PREA Policy and Intake and comprehensive age appropriate education within 10 days of intake.

Subsection (d):

HCJC Policy 115.333 pages 49-51 requires the Facility to ensure the resident education is accessible in formats as needed for LEP, deaf, visually impaired, or otherwise disabled residents. Materials are available in Spanish as needed. For situations that need other languages, the Agency utilizes the means of translation identified in Standard 115.316.

Subsection (e):

Resident files contain documentation of initial orientation completed at Intake and Education completed within 10 days of intake. Documentation is maintained in the Residents File.

Subsection (f):

The Agency and Facility ensures that educational materials are continuously and readily available and visible to residents about PREA. All housing areas and programming areas have PREA informational posters and the Auditor observed these throughout the pre- and post-facilities as well as the education building. Posters were located throughout out all areas of the Facility including day areas, education areas, public areas, visitation areas, and dining areas. Residents have access to their handbooks in their rooms and each unit has a copy of the handbook as well.

Standard 115.334: Specialized training: Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.334 (a)

- In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)
  ☒ Yes ☐ No ☐ NA

115.334 (b)

- Does this specialized training include techniques for interviewing juvenile sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

- Does this specialized training include proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

- Does this specialized training include sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

- Does this specialized training include the criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)
  ☒ Yes ☐ No ☐ NA

115.334 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does

not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)
☒ Yes ☐ No ☐ NA

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy page 51-53
2. Interviews with the following:
a. Investigative Staff
b. Agency Head
c. PREA Coordinator
4. Personnel Records for Investigative Staff (showing training records)

Findings (By Subsection):

Subsection (a):

Interviews with the Investigative Staff, Agency, and PREA Coordinator all indicated investigator training had been completed. Review of training records verified that investigators had received the required training.

Subsection (b):

Interviews with the Investigative Staff, Agency, and PREA Coordinator all indicated investigator training had been completed. Review of training records verified that investigators had received the required training.

Subsection (c):

Interviews with the Investigative Staff, Agency, and PREA Coordinator all indicated investigator training had been completed. Review of training records verified that investigators had received the required training.

Subsection (d):

HCJC has formally requested that the Police Department receive this training.

Standard 115.335: Specialized training: Medical and mental health care

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.335 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
  ☒ Yes ☐ No ☐ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
  ☒ Yes ☐ No ☐ NA

115.335 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency medical staff at the facility do not conduct forensic exams *or* the agency does not employ medical staff.)
  ☐ Yes ☐ No ☒ NA

115.335 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if

the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
  ☒ Yes ☐ No ☐ NA

- Do medical and mental health care practitioners contracted by or volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.335 pages 53-55
2. Interviews with the following:
a. Agency Head
b. PREA Coordinator
c. Mental Health Staff
3. Review of Medical and Mental Health Staff Training Records

Findings (By Subsection):

Subsection (a):

HCJC Policy 115.335 pages 53-55 requires all mental health and medical staff contracted by or volunteering at the facility to receive PREA related training specific to: 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. Interviews with the Agency Head, PREA Coordinator, and mental health staff all verified that this policy was followed. Additionally, file review showed documentation that these trainings were received and understood.

Subsection (b):

The medical contractors do not conduct forensic examinations of victims.

Subsection (c):

The Agency/Facility has documentation that this training has been provided, received and understood. The mental health contractors interviewed were knowledgeable of this training and the materials included.

Subsection (d):

Interviews and file review found that the contract mental health staff had received the required training pursuant to the standard.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.341 (a)

- Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident? ☒ Yes ☐ No

- Does the agency also obtain this information periodically throughout a resident's confinement? ☒ Yes ☐ No

115.341 (b)

- Are all PREA screening assessments conducted using an objective screening instrument? ☒ Yes ☐ No

115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (1) Prior sexual victimization or abusiveness? ☐ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (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? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (3) Current charges and offense history? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (4) Age? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (5) Level of emotional and cognitive development? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (6) Physical size and stature? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (7) Mental illness or mental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (8) Intellectual or developmental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (9) Physical disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (10) The residents' own perception of vulnerability? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? ☒ Yes ☐ No

115.341 (d)

- Is this information ascertained through conversations with the resident during the intake process and medical mental health screenings? ☒ Yes ☐ No

- Is this information ascertained during classification assessments? ☒ Yes ☐ No

- Is this information ascertained by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files? ☒ Yes ☐ No

115.341 (e)

- Has the agency implemented appropriate controls 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? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.341 pages 55-59
2. Behavioral Screening Form
3. MAYSI Screening Instrument
4. Random Resident Files
5. Interviews with the following:
a. Residents
b. Staff Responsible for Risk Screening
c. PREA Coordinator

Findings (By Subsection):

Subsection (a):

HCJC Policy 115.341 pages 55-59 requires risk assessment screening within 72 hours of the resident's admission into the Facility. File review indicated this information was gathered for all residents. At the time of the site review one resident had not received follow-up within 14 days. HCJC developed a referral form for mental health services at intake for immediate referral. On 7/23/2019 a second on-site review verified that HCJC had implemented this referral and follow-up process and this was verified by review of all intakes since July 1 with a history of sexual abuse or sexually abusive behavior.

Subsection (b):

The Facility uses an objective behavioral screening instrument. The screening instrument considers the youth's own perceptions of safety and other risk factors including gender non-conforming appearance, mannerisms or identification. The facility utilizes the MAYSI Screening Instrument and an interview based behavioral screening instrument for all youth.

Subsection (c):

The behavioral screening instrument attempts to ascertain information about all eleven (11) enumerated items in this subsection. File review of resident records found these data were collected for all residents. Staff interviews with Intake Staff also supported the finding of compliance with subsection.

Subsection (d):

HCJC Policy 115.341 pages 55-59 required information to be ascertained through conversations with the resident at the intake process as well as from court records, case files, medical or mental health information available and any other relevant information in the resident's file.

Subsection (e):

HCJC Policy 115.341 pages 55-59 provides that all information from the screening is kept confidential and only accessible by limited individuals. Interviews with staff who conduct behavioral screenings of residents indicate that there are appropriate controls on the dissemination within the facility of the

responses to questions in the screening. Files are kept securely. Only medical or mental health care staff in addition to supervisors has access.

Standard 115.342: Use of screening information

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.342 (a)

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments? ☒ Yes ☐ No

115.342 (b)

- Are residents 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? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

- Do residents in isolation receive daily visits from a medical or mental health care clinician? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

- Do residents in isolation also have access to other programs and work opportunities to the extent possible? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

115.342 (c)

- Does the agency always refrain from placing lesbian, gay, and bisexual (LGB) residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex (LGBTI) identification or status as an indicator or likelihood of being sexually abusive? ☒ Yes ☐ No

115.342 (d)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider, on a case-by-case basis, whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? ☒ Yes ☐ No

- When making housing or other program assignments for transgender or intersex residents, does the agency consider, on a case-by-case basis, whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems? ☒ Yes ☐ No

115.342 (e)

- Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident? ☒ Yes ☐ No

115.342 (f)

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? ☒ Yes ☐ No

115.342 (g)

- Are transgender and intersex residents given the opportunity to shower separately from other residents? ☒ Yes ☐ No

115.342 (h)

- If a resident is isolated pursuant to provision (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

- If a resident is isolated pursuant to provision (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

115.342 (i)

- In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS? (N/A if the facility *never* places residents in isolation for any reason.)
  ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.342 pages 59-61
2. Interviews with the following:
a. Random Residents
b. Staff Responsible for Risk Screening
c. PREA Coordinator
3. On-Site Review of Housing Units

Findings (By Subsection):

Subsection (a):

HCJC Policy 115.342 requires that the information obtained in the screening/intake process be used to make housing and other assignments. Interviews with staff indicate the information is used to make decisions on resident housing and programming. Policy and interviews with the PREA Coordinator and Agency Head determined compliance with subsection.

Subsection (b):

No isolation is utilized except for last resort and HCJC Policy ensures compliance with standard based on policy and interviews with the Facility Head. Isolation is used for youth at-risk of suicide or due to danger to others. Isolation is limited to extreme circumstances and residents in isolation have access to large-muscle exercise, educational programing, special education and access to medical or mental health care. Compliance with subsection was determined through interviews with the PREA Coordinator and review of HCJC Policy 115.342.

Subsection (c):

HCJC Policy 115.342 pages 59-61 provides that lesbian, gay, bisexual, transgender or intersex (LGBTI) residents are not to be assigned specific housing units based solely on such identification. Interviews with staff corroborate this is the practice of the Facility. If one or more of these statuses are identified the facility refrains from the assumption of higher risk of the resident being more likely of sexually abusive behavior and identifies these statuses as a risk of sexual abuse or harassment indicator and carefully makes housing selections based on these data and the resident's own perceptions of safety. The determination of compliance was met based on resident file review and interviews with security staff and the PREA Coordinator.

Subsection (d):

HCJC Policy 115.342 pages 59-61 and interviews with staff indicate that the placement of any transgender or intersex residents to the facility would be made on a case-by-case basis. Staff interviews indicated there have been no transgender or intersex residents to date; however, staff interviews and training records indicate compliance. Detention receives short-term youth who average less than 32 days at the facility. All residents placed in detention occupy a single cell housing unit. Long-term residents in open bay living areas have been adjudicated or are placed by Child Protective Services and there are multiple records reviewed; along with the residents own perceptions included in housing placement.

Subsection (e):

HCJC Policy 115.342 pages 59-61and and the interview with the Agency Head indicated that placement and programming assignments for each transgender and intersex resident would be reassessed at least twice per year to review any threats to the resident's safety.

Subsection (f):

HCJC Policy 115.342 pages 59-61 requires that transgender and intersex resident's own views regarding their safety shall be given serious consideration. Interviews with staff corroborate that this

would be the practice if these residents were in the Facility which all staff indicated they do not believe they have had a transgender or intersex resident in the Facility to date.

Subsection (g):

HCJC Policy 115.342 pages 59-61 ensures transgender and intersex residents can shower separately from other residents. The shower area only allows one resident to shower at a time and staff ensures that residents have privacy. Facility Bathing Procedures indicate that all residents shower separately and at no time are undressed in front of staff or other residents.

Subsection (h):

No isolation is utilized except for last resort and HCJC Policy ensures compliance with standard based on policy and interviews with the Facility Head. Isolation is used for youth at-risk of suicide or due to danger to others. Isolation is limited to extreme circumstances and residents in isolation have access to large-muscle exercise, educational programing, special education and access to medical or mental health care. All instances of isolation are documented in the resident's records. Compliance with subsection was determined through interviews with the PREA Coordinator and review of HCJC Policy 115.342.

Subsection (i):

No isolation is utilized except for last resort and HCJC Policy ensures compliance with standard based on policy and interviews with the Facility Head. Isolation is used for youth at-risk of suicide or due to danger to others. Isolation is limited to extreme circumstances and residents in isolation have access to large-muscle exercise, educational programing, special education and access to medical or mental health care. All instances of isolation are documented in the resident's records and interviews verified that a review would occur every 30 days; however, the facility indicates isolation is limited and no instances have occurred last 30 days. Compliance with subsection was determined through interviews with the PREA Coordinator and review of HCJC Policy 115.342.

REPORTING

Standard 115.351: Resident reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.351 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

115.351 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No

- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No

- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No

- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment? (N/A if the facility *never* houses residents detained solely for civil immigration purposes.) ☒ Yes ☐ No ☐ NA

115.351 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? ☒ Yes ☐ No

- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.351 (d)

- Does the facility provide residents with access to tools necessary to make a written report? ☒ Yes ☐ No

- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.41 pages 62-66
2. Interviews with the following:
a. Random Staff
b. PREA Coordinator
c. PREA Compliance Manager
d. Resident Interviews
3. On-Site Review of reporting mechanisms (Grievance, Hot Line Numbers)

Subsection (a)

On-site review found multiple internal ways for residents to report sexual abuse, sexual harassment, retaliation and/or staff neglect privately. All residents have access to materials to file a grievance and indicated that they knew how to file, and that this could be done anonymously. All residents stated that they had access to the hotline numbers and that staff would allow them to use them if requested. They indicated that staff did not listen to hotline calls. These mechanisms were also indicated by random staff, PREA Coordinator and PREA Compliance Manager.

Subsection (b)

Residents, staff, and the PREA Coordinator all reported that residents have access to the TJJD hotline and that these calls are anonymous upon request. The hotline numbers were tested and were in working order.

Subsection (c)

Policy 115.351 requires staff to accept verbal reports of sexual abuse, sexual harassment, retaliation or neglect. Policy requires that staff act on all reports immediately to ensure the safety of the resident. Staff and residents both indicated that staff would respond to verbal reports. Staff indicated that they would suggest the resident write it down once safety was insured but would document as soon as all reporting was completed, and the resident's safety was ensured.

Subsection (d)

During staff interviews all staff were able to identify ways to report privately. This included utilizing the TJJD hotline, calling law enforcement, or reporting to Child Protective Services. Staff and residents both indicated that staff provide the needed materials for completing a written report to residents.

Standard 115.352: Exhaustion of administrative remedies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.352 (a)

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse. ☒ Yes ☐ No

115.352 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☐ NA

- Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.). ☐ Yes ☐ No ☒ NA

- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.352 pages 64-66
2. Interview with Agency Head.

Findings (By Subsection):

Subsection (a):

Policy and Interviews indicate that the Agency and Facility are exempt from 115.352. HCJC Policy states any allegations regarding sexual abuse reported through the grievance system would immediately be forwarded to the PREA Coordinator. The allegation would be investigated regardless of how much time has passed utilizing the policy and procedures for investigations.

Standard 115.353: Resident access to outside confidential support services and legal representation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.353 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making assessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☐ Yes ☐ No

- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? (N/A if the facility *never* has persons detained solely for civil immigration purposes.) ☐ Yes ☐ No ☐ NA

- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☐ Yes ☐ No

115.353 (b)

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? ☐ Yes ☐ No

115.353 (c)

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? ☐ Yes ☐ No

- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☐ Yes ☐ No

115.353 (d)

- Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation? ☐ Yes ☐ No

- Does the facility provide residents with reasonable access to parents or legal guardians? ☐ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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Evidence Reviewed (documents, interviews, site review):

1. HCJC Policy 115.343 pages 66-68
3. Memorandum of Understanding between Agency and the HCWC
4. Interviews with the following:
a. Random Residents
b. PREA Coordinator
c. PREA Compliance Manager
5. On-site review of housing areas and program areas of Facility; specifically looking for information about outside support services for residents
Findings (By Subsection):

Subsection (a):

The Agency has a MOU with the HCWC. This MOU covers victim advocacy services during forensic exams. It also includes crisis intervention counseling and referrals to services for victims. During the on-site review of the physical plant, the Auditor saw brochures, posters or information on the HCWC in the Resident areas with other postings. During interviews with random residents, the majority understood the orientation material and education materials and recalled these services being reviewed; however, three stated they did not remember any details. Resident files held copies of the materials reviewed with residents and their signature indicating they had received and understood the information.

Subsection (b):

The MOU with HCWC indicates that services are confidential.

Subsection (c):

The Agency has an executed Memorandum of Understanding between Agency and the HCWC.

Subsection (d):

HCJC Policy115.343 indicates that residents are required to have reasonable and confidential access to their attorneys or other legal representation and reasonable to parents or legal guardians. Resident interviews confirmed this practice with parents/legal guardians, case workers and probation officers. Residents indicated they could contact their attorney; however, none had contacted via phone and had only seen in court but indicated they had not requested to contact their attorney.

Standard 115.354: Third-party reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.354 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.354 pages 68-69

2. Third-Party Reporting Information Posters
3. Posting on Website: https://hayscountytx.com/wpfb-file/prea-policy-and-procedure-docx/

Findings (By Subsection):

Subsection (a):

HCJC Policy provides for the receipt of third-party reports of sexual abuse and sexual harassment. In the public waiting area for parents, guardians and visitors the Facility has notices indicating the Zero Tolerance of sexual abuse and sexual harassment and provides hotline numbers to report suspected sexual abuse or sexual harassment of residents.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.361 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

115.361 (b)

- Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws? ☒ Yes ☐ No

115.361 (c)

- Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? ☒ Yes ☐ No

115.361 (d)

- Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws? ☒ Yes ☐ No

- Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

115.361 (e)

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office? ☒ Yes ☐ No

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation 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? ☒ Yes ☐ No

- If an alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? ☒ Yes ☐ No

- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation? ☒ Yes ☐ No

115.361 (f)

- Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.361 69-73
2. Coordinated Response Plan
3. Interviews with the following:
a. Random Staff
b. Agency Head
c. Mental Health Staff
d. PREA Coordinator
e. PREA Compliance Manager

Findings (By Subsection):

Subsection (a):

HCJC Policy 69-73 requires staff to report immediately all the information delineated in this subsection (i.e., sexual abuse, sexual harassment, retaliation, staff neglect, and violations of staff responsibilities). Interviews with random staff, Agency Head, Mental Health Staff and the PREA Coordinator indicate they understand their reporting obligations. The Coordinated Response Plan clearly outlines responsibilities to report and the responsibilities of the first responders to report.

Subsection (b):

HCJC Policy 69-73 requires Facility staff to comply with mandatory child abuse reporting laws under Texas Family Code and report via the hotline immediately in accordance to the standard. Interviews with staff indicate that staff have received training on this topic and understand their role as a mandatory reporter. Staff interviews indicated that all staff would report to Child Protective Services, their supervisor, and Law Enforcement.

Subsection (c):

HCJC Policy 69-73 prohibits staff from revealing confidential information related to a report of sexual abuse except to the extent necessary to make treatment, investigation, and/or other security management decisions. Interviews with staff indicate their understanding of this confidentiality provision.

Subsection (d):

Interviews with mental health staff indicate they comply with this subsection regarding mandatory reporting laws and disclosing the limitations of their confidentiality. Mental Health Service Contracts include the requirement of the provider to disclose the limitations of their confidentiality upon initiation of services.

Subsection (e):

HCJC Policy 69-73 requires parental notification of abuse of a resident; as well as specifically addresses the requirements of this subsection regarding notification to parents, legal guardians, Child Protective Services, and the resident's attorney.

Subsection (f):

All allegations of sexual abuse and sexual harassment are reported to the Facility investigator(s) by the PREA Coordinator . The staff member or supervisor who completes the Incident Report Form forwards it to the Agency Head and PREA Coordinator who are all members of responder team. The PREA Coordinator is the lead on all administrative investigations unless there is a conflict of interest as determined by the Agency Head. The PREA Coordinator, Agency Head and other investigators are all well qualified and have completed the required training.

Standard 115.362: Agency protection duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.362 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy115.362 pages 73-74
2. Coordinated Response Plan
3. Interviews with the following:
a. Random Staff
b. Agency Head
c. PREA Coordinator
d. Residents

Findings (By Subsection):

Subsection (a):

The Agency reports in their PAQ that they have had no determinations made that a resident was subject to substantial risk of imminent sexual abuse. HCHS addresses the agency policy when learning a resident is subject to a substantial risk of imminent sexual. The Staff First Responder Duties in the policy indicates the actions to be taken. Additionally, the written Coordinated Response Plan of the Facility also indicates immediate action, what actions are to be take and by each position. Staff Interviews, including Random Staff, Agency Head and PREA Coordinator all indicated that staff would take immediate response and defined immediate that indicated that all interviewed understood the urgency of the protection of a resident from imminent threat. While no residents had made an allegation of abuse or imminent threat of sexual abuse, they constantly indicated that staff react to other

issues immediately based on verbal and they are highly supervised. Residents stated they believe staff would take immediate action to protect them.

Standard 115.363: Reporting to other confinement facilities

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.363 (a)

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? ☒ Yes ☐ No

- Does the head of the facility that received the allegation also notify the appropriate investigative agency? ☒ Yes ☐ No

115.363 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? ☒ Yes ☐ No

115.363 (c)

- Does the agency document that it has provided such notification? ☒ Yes ☐ No

115.363 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.363 pages 75-76
2. Interviews with the following:
a. Agency Head
b. PREA Coordinator

Findings (By Subsection):

Subsection (a):

The Agency and Facility reports in the PAQ that in the past 12 months they have received no allegations that a resident was abused while confined at another Facility; this was confirmed in the interviews with the Agency Head. Additionally, they have received no allegations of sexual abuse from other facilities. HCJC Policy requires the Agency Head to provide the required notifications under this section regarding a resident's abuse while confined at other facilities. Interviews with the Agency Head indicate they are knowledgeable about the requirements of this section and that this notification would occur when any allegations are received.

Subsection (b):

HCJC Policy 115.364 requires notification within 72 hours as required by this standard. Interviews with the Agency Head indicate they are knowledgeable about the requirements of this section and that they would adhere to this mandatory timeframe.

Subsection (c):

HCJC Policy 115.364 requires the Facility to document when all such notifications are provided and to whom. Interviews with the Agency Head indicate they are knowledgeable about the requirements of this section and that they would comply with this requirement should they receive any allegations.

Subsection (d):

HCJC Policy 115.363 requires all allegations are investigated in accordance with this standard. Interviews with the Agency Head indicate they are knowledgeable about the requirements of this section and that they would adhere to this investigation requirement for any allegations that may be received.

Standard 115.364: Staff first responder duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.364 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?
  ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: 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, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: 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, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

115.364 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.364 pages 76-79
2. Coordinated Response Plan
3. Interviews with the following:
a. Security Staff and Non-Security Staff First Responders
b. Random Staff
c. PREA Coordinator
d. Agency Head

Findings (By Subsection):

Subsection (a):

HCJC Policy 115.364 details the first responder duties for a security staff member or a non-security staff member (i.e., such as kitchen, janitorial, mental health) in accordance with this subsection. Interviews onsite with the Agency Head and PREA Coordinator indicated as did all Pre-Audit materials that there have been no allegations of sexual abuse or sexual harassment in the past 36 months. HCJC and the Coordinated Response Plan documents is clear that first responders are to only preserve and protect the scene along with the duties regarding protection of evidence on the victim and abuser. It was evident in the interviews with random staff indicated that these protocols were followed.

Subsection (b):

HCJC and the Coordinated Response Plan are clear on the response of all staff. Interviews with staff showed consistent responses of ensuring safety, separation of the two and maintaining physical evidence. All were able to describe their role and actions to preserve evidence on the victim and alleged perpetrator.

Standard 115.365: Coordinated response

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.365 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.365 pages 79-80

2. Coordinated Response Plan
3. Interviews with the following:
a. Random Staff
b. PREA Coordinator
c. Agency Head
4. Contact and Verification with the Central Texas Medical Center verifying SANE Nurse.
6. Memorandum of Understanding between the Agency and HCWC.
7. Memorandum of Understanding between the Agency and the San Angelo Police Department
8. Sexual Abuse First Responders Protocol – Agency's Coordinated Response Plan
9. Email correspondence between PREA Coordinator, Central Texas Medical Center, HCWC, and Police Department

Findings (By Subsection):

Subsection (a):

HCJC Policy 115.365 states the policy that requires a written Coordinated Response Plan. The Coordinated Response Plan indicated that it followed the structural design from first response including First Responders, Notifications, Investigations, Medical and Mental Health Services, Forensics Exams (SANE), Coordination with Law Enforcement, Advocacy, Protection and Retaliation Monitoring and PREA Incident Review Team meeting within 30 days. The Coordinated Response Plan provided included the details of the subsection and responsibilities of each party. The plan detained when, who, and how notifications occur, and the roles of each party involved. Review of the MOU's with the San Marcos Police Department, the HCWC and verification SANE Services at the Hospital were completed, Email Correspondence from the Agency and the Hospital and Police Department were confirmed.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.366 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? ☐ Yes ☒ No

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.366 pages 80-81
2. Interviews with the following:
a. Agency Head

Findings (By Subsection):

Subsection (a):

An interview with the HCJC Agency Head noted that the agency does not have, nor has it had, any collective bargaining agreements that were completed since August of 2012.

Standard 115.367: Agency protection against retaliation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.367 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? ☒ Yes ☐ No

- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

115.367 (b)

- Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services, for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations,? ☒ Yes ☐ No

115.367 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: The conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: The conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Any resident disciplinary reports? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Resident housing changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Resident program changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Negative performance reviews of staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Reassignments of staff? ☒ Yes ☐ No

- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

115.367 (d)

- In the case of residents, does such monitoring also include periodic status checks? ☒ Yes ☐ No

115.367 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation? ☒ Yes ☐ No

115.367 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.367 pages 81-83
2. Interviews with the following:
a. Agency Head
b. PREA Coordinator
c. Designated Staff Member Charged with Monitoring Retaliation

Findings (By Subsection):

Subsection (a):

HCJC Policy protects residents and staff from retaliation as required by this subsection. Interviews with the Agency Head, PREA Coordinator and Staff Charged with Monitoring Against Retaliation verified there have been no allegations made in the past 12 months that would initiate the protocols of monitoring for retaliation.

Subsection (b):

HCJC Policy provides multiple measures to protect residents from retaliation including housing changes, reassessments and reassignment of alleged perpetrators.

Subsection (c):

HCJC Policy 115.367 requires the monitoring of residents or staff who report sexual abuse to see if there is any retaliation occurring. Policy requires an assigned Administrator to formally conduct monitoring every 7 days and to document monitoring for a minimum of 90 days. Additionally, the PREA Coordinator and Agency have been designated to also monitor retaliation and will work cooperatively

with these other individuals. Interviews with the Agency Head indicated that monitoring beyond 90 days would continue if needed.

Subsection (d):

HCJC Policy requires the monitoring of retaliation for the required 90 days following a report of sexual abuse. The policy further requires periodic status checks every 7 days throughout a resident's confinement.

Subsection (e):

HCJC Policy 115.367 ensures residents and staff are protected against retaliation. Interviews with the Agency Head, PREA Coordinator and Staff Charged with Monitoring Against Retaliation indicated protective action would be taken to ensure the safety of the resident from all parties regarding retaliation for reporting sexual abuse.

Subsection (f):

HCJC Policy provides that the agency's obligation to monitor terminates if the agency determines the allegation is unfounded.

Standard 115.368: Post-allegation protective custody

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.368 (a)

- Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.368 pages 83-84
2. Interviews with the following:
a. Agency Head
b. PREA Coordinator
3. On-site review of housing areas specifically looking at isolation rooms to observe any residents in isolation

Findings (By Subsection):

Subsection (a):

HCJC Policy 115.368 and interviews with the Agency Head and PREA Coordinator confirm that the facility does not utilize segregated housing for residents who have suffered sexual abuse or sexual harassment. The facility utilizes single cells for detention and for safety a resident could be moved into another area or single cell; however, this is not segregated housing.

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.371 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).]
  ☐ Yes ☒ No ☐ NA

115.371 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334? ☒ Yes ☐ No

115.371 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses?
  ☒ Yes ☐ No

- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.371 (d)

- Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation? ☒ Yes ☐ No

115.371 (e)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? ☒ Yes ☐ No

115.371 (f)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?
  ☒ Yes ☐ No

- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☐ Yes ☐ No

115.371 (g)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No

- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

115.371 (h)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? ☒ Yes ☐ No

115.371 (i)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?
  ☒ Yes ☐ No

115.371 (j)

- Does the agency retain all written reports referenced in 115.371(g) and (h) 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?
  ☒ Yes ☐ No

115.371 (k)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation?
  ☒ Yes ☐ No

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

- When an outside agency investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.371 pages 84-87
2. Training records for Investigative Staff
3. Interviews with the following:
a. Agency Head
b. PREA Coordinator
c. Investigative Staff
4. Coordinated Response Plan

Findings (By Subsection):

Subsection (a):

The Agency conducts administrative investigations, but all criminal investigations are conducted by San Marcos Police Department. Policy requires that in administrative investigations, staff will investigate promptly, thoroughly, and objectively all allegations of sexual abuse, sexual harassment, and retaliation.

Subsection (b):

HCJC training records verified special training in sexual abuse investigations involving juvenile victims pursuant to 115.334.

Subsection (c):

Agency investigative staff does not collect any physical DNA evidence; the San Marcos Police Department is responsible for all forensic evidence collection. The Agency follows their Coordinated Response Plan related to protecting and preserving the crime scene and any potential forensic evidence. Agency investigators do the administrative investigation and gather relevant witness statements, etc. in cooperation with San Marcos Police Department's criminal investigation.

Subsection (d):

HCJC Policy 115.371 prohibits an investigation from being terminated solely because the source of the allegation recants. The interview with the PREA Coordinator corroborated this policy is followed in practice.

Subsection (e):

HCJC Policy 115.371 requires that the investigator must consult with the local prosecutor prior to conducting compelled interviews. The interview with the Agency Head and PREA Coordinator supported this.

Subsection (f):

HCJC policy 115.371 requires that HCJC track the requirements of this subsection regarding determining the credibility of an alleged victim and the prohibition on utilizing a polygraph test or other truth detecting device. The interview with the Agency Head and PREA Coordinator corroborated this policy is followed in practice.

Subsection (g):

HCJC Policy 115.371 tracks the requirements of this section related to determining whether staff actions or failures to act contributed to the abuse and the documentation that must be maintained.

Subsection (h):

The San Marcos Police Department conducts all criminal investigations for allegations of criminal activity in the Facility. There have been no investigations in the past 12 months.

Subsection (i):

Law enforcement is responsible for sending all criminal cases to the criminal prosecutor for the county. Interviews with the Agency Head and PREA Coordinator confirm that substantiated cases have been referred for prosecution. There have been no investigations in the past 12 months.

Subsection (j):

HCJC Policy 115.371 meets the requirement of this section related to records retention and complies with this subsection.

Subsection (k):

HCJC Policy 115.371 provides that the departure of the alleged abuser or victim shall not provide a basis for terminating an investigation. The Auditor interviewed the lead investigator who indicated that the investigation would continue despite these circumstances.

Subsection (l):

HCJC Policy 115.371 requires that outside investigations in the juvenile facility follow the requirements of this standard.

Subsection (m):

HCJC Policy 115.371 requires the agency to cooperate with all outside investigators which in their case are normally the San Marcos Police Department.

Standard 115.372: Evidentiary standard for administrative investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.372 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.372 pages 87-88
2. Interviews with the following:
a. Agency Head
b. PREA Coordinator

Findings (By Subsection):

Subsection (a):

HCJC prohibits the Agency from imposing a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment have occurred. The Auditor interviewed the Agency Head and PREA Coordinator who indicated that the standard used is preponderance of the evidence.

Standard 115.373: Reporting to residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.373 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? ☒ Yes ☐ No

115.373 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in the agency's facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

115.373 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident

whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.373 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.373 (e)

- Does the agency document all such notifications or attempted notifications? ☒ Yes ☐ No

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.373 pages 88-90
2. Interviews with the following:
a. Agency Head
b. PREA Coordinator
c. PREA Compliance Manager
3. Review of File with Resident Contact

Findings (By Subsection):

Subsection (a):

HCJC requires resident notification following an investigation into an allegation of sexual abuse suffered at HCJC. Interviews completed with the Agency Head, PREA Coordinator and PREA Compliance Manager who are all members of the PREA Incident Review Team all indicated this was policy. There have been no investigations in the past 12 months.

Subsection (b):

Interviews completed with the Agency Head, PREA Coordinator and PREA Compliance Manager who are all members of the PREA Incident Review Team all indicated this was policy. A review of investigation files found that these notifications had been provided.

Subsection (c):

HCJC Policy 115.373 details the required notifications pursuant to this subsection of the PREA standards.

Subsection (d):

HCJC Policy115.373 details the required notifications pursuant to this subsection of the PREA standards.

Subsection (e):

HCJC Policy 115.373 details the required notifications pursuant to this subsection of the PREA standards.

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.376 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No

115.376 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☒ Yes ☐ No

115.376 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) 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? ☒ Yes ☐ No

115.376 (d)

- Are 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, reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No

- Are 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, reported to: Relevant licensing bodies? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.376 pages 90-91
2. Interviews with the following:
a. Agency Head
b. PREA Coordinator
c. Human Resource Manager

Findings (By Subsection):

Subsection (a):

HCJC Policy 115.376 pages 90-91 provides that employees shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse, sexual harassment and retaliation policies. Interviews with the Agency Head, PREA Coordinator, and PREA Compliance Manager supported that this policy would be implemented, and termination was the presumptive action. Review of investigation files verified that this policy had been enforced.

Subsection (b):

HCJC Policy 115.376 pages 90-91 provides that if an allegation of sexual abuse of a resident by an employee is substantiated, that employee shall be terminated. Interviews with the Agency Head, PREA Coordinator, and PREA Compliance Manager indicated this policy had and would continue to be implemented. There has been no investigation sin the past 12 months.

Subsection (c):

HCJC Policy 115.376 pages 90-91 provides that discipline is given based upon the requirements of this subsection and is commensurate with the nature and circumstances of the conduct, the staff member's disciplinary history, and sanctions imposed for comparable offenses by other staff with similar histories. Interviews with the Agency Head and PREA Coordinator; there have been no investigations completed in the past 12 months verify this policy has been followed.

Subsection (d):

Interviews with the PREA Coordinator and Agency Head indicated terminations for violation of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, unless clearly not criminal, are reported to law enforcement and childcare licensing.

Standard 115.377: Corrective action for contractors and volunteers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.377 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No

- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No

- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

115.377 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.377 page 92-93
2. Interviews with the following:
a. Agency Head
b. PREA Coordinator
c. Human Resources Manager

Findings (By Subsection):

Subsection (a):

HCJC Policy 115.377 provides that any contractor, volunteer, or intern who engages in sexual abuse shall be prohibited from contact with residents. Potentially criminal conduct must be reported to the San Marcos Police Department and Child Protective Services. Interviews with the Agency Head and PREA

Coordinator indicate that there have been no Volunteers or Contractors at the Facility that have violated agency sexual abuse or sexual harassment policies in the past 12 months and this Policy would be strictly enforced.

Subsection (b):

HCJC Policy 115.377 requires the agency to take appropriate remedial measures and to consider whether to prohibit further contact with residents based on the conduct as required by this subsection. Interviews with the Agency Head and PREA Coordinator indicate that there have been no Volunteers or Contractors at the Facility that have violated agency sexual abuse or sexual harassment policies in the past 12 months and this Policy would be strictly enforced.

Standard 115.378: Interventions and disciplinary sanctions for residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.378 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process? ☒ Yes ☐ No

115.378 (b)

- Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.378 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? ☒ Yes ☐ No

115.378 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions? ☒ Yes ☐ No

- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education? ☒ Yes ☐ No

115.378 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

115.378 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No

115.378 (g)

- If the agency prohibits all sexual activity between residents, does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.378 page 93-95
2. Interviews with the following:
a. Agency Head
b. PREA Coordinator
c. PREA Compliance Manager
d. Random Staff
e. Mental Health Staff

Findings (By Subsection):

Subsection (a):

HCJC Policy 115.378 provides that residents may be subject to disciplinary sanctions only pursuant to a formal disciplinary process when there is an administrative and/or criminal finding that the resident engaged in resident-on-resident sexual abuse. Interviews with the Agency Head, PREA Coordinator, and PREA Compliance Manager indicate that this policy is followed.

Subsection (b):

HCJC Policy 115.378 provides that residents may be subject to disciplinary sanctions only pursuant to a formal disciplinary process. Agency Policy states that disciplinary sanctions shall be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories.

Subsection (c):

HCJC Policy 115.378 provides that the disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.

Subsection (d):

HCJC Policy 115.378 addresses the requirements of this subsection regarding offering residents' therapy, counseling or other interventions as part of discipline. Policy prohibits the agency from requiring participation as a condition of access to general programming, but it may be required as a condition of access to any reward-based behavior management system or other behavior-based incentives. Interviews with mental health staff indicate the practice is compliant with this subsection.

Subsection (e):

HCJC Policy 115.378 permits a resident to be disciplined for sexual contact with a staff member if the staff member did not consent to such contact.

Subsection (f):

HCJC Policy 115.378 provides that a report of sexual abuse made in good faith shall not constitute a false report even if the investigation does not establish evidence sufficient to substantiate the allegation.

Subsection (g):

HCJC Policy 115.378 prohibits all sexual activity between residents in the Facility and allows the Facility to discipline violators in accordance with the resident discipline plan.

MEDICAL AND MENTAL CARE

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.381 (a)

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (b)

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (c)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law? ☒ Yes ☐ No

115.381 (d)

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.381 pages 95-97
2. Interviews with the following:
a. Staff Responsible for Risk Screening
b. Mental Health Staff
c. Agency Head
d. PREA Coordinator
3. Resident Intake Form
4. On-site review of housing areas in pre and post programs specifically looking at intake area and where resident files are stored to determine security of records

Findings (By Subsection):

Subsection (a):

HCJC offers all youth a medical and mental health appointment within 14 days of their intake screening. During the on-site audit a review of randomly selected files showed 1 resident of three who was not provided with a follow-up meeting with mental health staff. HCJC created a referral system to mental health based on intake information collected on the behavioral screening. Follow-up visit on 7/22/2019 showed this system was in place and was being fully implemented for the three applicable intakes since June 17, 2019.

Subsection (b):

HCJC offers all youth a medical and mental health appointment within 14 days of their intake screening. During the on-site audit a review of randomly selected files showed 1 resident of three who was not provided with a follow-up meeting with mental health staff. HCJC created a referral system to mental health based on intake information collected on the behavioral screening. Follow-up visit on 7/22/2019 showed this system was in place and was being fully implemented for the three applicable intakes since June 17, 2019.

Subsection (c):

HCJC Policy 115.381 provides that information gained at the intake screening is confidential and strictly limited to medical and mental health practitioners and other staff as required by their job function and responsibilities. During the on-site review of the physical plant, the Auditor was shown where resident files are securely located, requiring supervisory approval for access and only if for a legitimate business/Agency/Facility purpose.

Subsection (d):

Interviews with medical and mental health personnel indicate that these contract providers disclose the limits of confidentiality to residents and obtain informed consent. Interviews with the Agency Head and PREA Coordinator verified this and indicated that this is stated in their contracts for service which was viewed by the auditor.

Standard 115.382: Access to emergency medical and mental health services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.382 (a)

- Do resident victims of sexual abuse 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 judgment? ☒ Yes ☐ No

115.382 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362? ☒ Yes ☐ No

- Do staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.382 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☒ Yes ☐ No

115.382 (d)

- Are treatment services 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? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.382 pages 97-99
2. Interviews with the following:
a. First Responders
b. Mental Health Staff
c. Agency Head
d. PREA Compliance Manager
e. PREA Coordinator
3. Coordinated Response Plan

Findings (By Subsection):

Subsection (a):

HCJC Policy 115.382 pages 97-99 and the Coordinated Response Plan demonstrates compliance with this subsection. Interviews with a mental health providers, First Responders, Agency Head, and PREA Coordinator indicate a victim would receive the medical and mental health care services required by this subsection.

Subsection (b):

Interviews with first responders and PREA Coordinator indicate the practice of the Facility is compliant with this subsection. The victim will be protected as will the crime scene until the police and necessary medical personnel arrive on site or until the victim is transported. This is also stated in the Coordinated Response Plan.

Subsection (c):

HCJC Policy 115.382 pages 97-99 provides that a victim will be offered timely access to medical treatment and testing in accordance with professionally accepted standards of care where medically appropriate to include emergency contraception and sexually transmitted infections prophylaxis; interviews with the PREA Coordinator supported that this policy would be followed.

Subsection (d):

HCJC Policy 115.382 pages 97-99 provides that treatment services are provided to the victim without financial cost to the victim. Additionally, treatment services are provided regardless of whether the victim names the abuser or cooperates with the investigation.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.383 (a)

- Does the facility offer 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? ☒ Yes ☐ No

115.383 (b)

- Does the evaluation and treatment of such victims 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? ☒ Yes ☐ No

115.383 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

115.383 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☒ Yes ☐ No ☐ NA

115.383 (e)

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☒ Yes ☐ No ☐ NA

115.383 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

115.383 (g)

- Are treatment services 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? ☒ Yes ☐ No

115.383 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.382 pages 99-102
2. Interviews with the following:
a. Mental Health Staff
b. Agency Head
c. PREA Coordinator
3. Resident File Review

Findings (By Subsection):

Subsection (a):

It is HCJC Policy (HCJC Policy 115.382 pages 99-102) to provide specialized medical and mental health services to any resident who has been the victim and/or the perpetrator of sexual abuse whether in the Facility or prior to his or her confinement. Interviews with the PREA Coordinator and Compliance Manager; as well as documentation indicated this had been implemented and a youth reporting past abuse was offered medical screening and mental health services.

Subsection (b):

Interviews with the PREA Coordinator and mental health staff indicate victims would be provided with appropriate levels of services as required by this subsection.

Subsection (c):

HCJC Policy 115.382 pages 99-102 provides that victims will be provided medical and mental health services that are determined by medical and mental health practitioners to be necessary according to their professional judgement; Central Texas Medical Center is a predominant care Facility in the community and policy states victims would be taken here for services for SANE. Mental Health services are available onsite and from HCWC House. Interviews and Resident File Review indicated that mental health professionals were onsite and available to youth five days per week and on-call. Policy, Interviews and Resident File Review indicated that ongoing medical and mental health services were provided regularly.

Subsection (d):

HCJC Policy 115.382 pages 99-102 ensures that victims are offered pregnancy tests.

Subsection (e):

HCJC Policy 115.382 pages 99-102 ensures that if pregnancy results from conduct specified in paragraph (d) of this section shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services.

Subsection (f):

HCJC Policy 115.382 pages 99-102 provides that victims of sexual abuse while incarcerated shall be provided testing for sexually transmitted infections as medically appropriate.

Subsection (g):

HCJC Policy 115.382 pages 99-102 provides that treatment services are provided to the victim without financial cost to the victim. Additionally, treatment services are provided regardless of whether the victim names the abuser or cooperates with the investigation.

Subsection (h):
HCJC provides that facility shall attempt to conduct a mental health evaluation of a resident-on-resident abuser within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health professionals. Policy and interviews with mental health staff indicate this would be the practice if this situation occurred.

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.386 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☒ Yes ☐ No

115.386 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

115.386 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

115.386 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.386 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.386 pages 102-104
2. Interviews with the following:
a. Agency Head
b. PREA Compliance Manager
c. PREA Coordinator
3. Meeting Notes of Incident Review Team Meetings
4. Coordinated Response Plan

Findings (By Subsection):

Subsection (a):

HCJC Policy 115.386 pages 102-104 requires the Facility to conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded. There have been no incidents to review in the past 12 months.

Subsection (b):

HCJC Policy 115.386 pages 102-104requires the review to ordinarily occur within 30 days of the conclusion of the investigation. Interviews with the PREA Compliance Manager indicated that this is the practice of the Facility to adhere to the 30 day time requirement but there were no incidents in the past 12 months.

Subsection (c):

HCJC Policy 115.386 pages 102-104 details the composition of the review team which includes the managers, supervisors, investigators and medical or mental health practitioners. The documentation of completed reviews provided with the PAQ and on-site verified compliance with subsection.

Subsection (d):

HCJC Policy 115.386 pages 102-104 and interviews with the PREA Coordinator and Compliance Manager indicate compliance. There have been no incidents in the past 12 months.

Subsection (e):

HCJC Policy 115.386 pages 102-104 and interviews with the PREA Coordinator and Compliance Manager indicate compliance. There have been no incidents in the past 12 months.

Standard 115.387: Data collection

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.387 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

115.387 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? ☒ Yes ☐ No

115.387 (c)

- Does the incident-based data 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? ☒ Yes ☐ No

115.387 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? ☒ Yes ☐ No

115.387 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☒ Yes ☐ No ☐ NA

115.387 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)
  ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.387 pages 104-106
2. Bureau of Justice Statistics Survey of Sexual Victimization, 2018 (completed report)
3. Aggregate Data Presented on the Agency Website https://hayscountytx.com/wpfb-file/prea-statistics_2-xlsx/

Findings (By Subsection):

Subsection (a):

HCJC Policy 115.387 pages 104-106 requires the facility to collect accurate and uniform data for every allegation of sexual abuse that occurs in the Agency. These data were verified on the Agency's Website during the onsite review.

Subsection (b):

HCJC Policy 115.387 pages 104-106 requires the Agency to aggregate annually all sexual abuse incident data. These data were verified on the Agency's Website during the onsite review.

Subsection (c):

HCJC Policy 115.387 pages 104-106 details the types of data to be collected and it is, at a minimum, the data necessary to complete the Survey of Sexual Violence conducted by the Department of Justice and the Bureau of Justice Statistics. These data were verified on the Agency's Website during the onsite review.

Subsection (d):

HCJC Policy 115.387 pages 104-106 requires the Facility to maintain, review and collect data as required by this subsection. These data were verified on the Agency's Website during the onsite review.

Subsection (e):

HCJC Policy 115.387 pages 104-106 requires the agency to collect incident-based aggregate data from all private facilities to which the department contracts for the placement of juveniles. This data was viewed on the Agency's Website.

Subsection (f):

HCJC Policy 115.387 pages 104-106 requires the Agency to provide all data from the previous calendar year to the Department of Justice no later than June 30th of each year upon request. The Agency presented the 2018 SSV and posted these same data with 2017 and 2016 data on the Agency's website. This was verified at the time of the onsite review.

Standard 115.388: Data review for corrective action

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.388 (a)

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.388 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☒ Yes ☐ No

115.388 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.388 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.388 pages 106-108
2. Bureau of Justice Statistics Survey of Sexual Victimization, 2018 (completed report)
3. Aggregate Data Presented on the Agency Website https://hayscountytx.com/wpfb-file/prea-statistics_2-xlsx/
4. Interviews with:
a. Agency Head
b. PREA Coordinator

Findings (By Subsection):

Subsection (a):

HCJC Policy 115.388 pages 106-108 requires an annual report be completed to assess the effectiveness of prevention, detection and response policies, practices and training.

Subsection (b):

HCJC requires the annual report include a comparison of the current year's data and the corrective actions with those from prior years and shall provide an assessment of the department's progress in addressing sexual abuse. Review of the Annual Report for 2018 verified that a comparison of the current year to previous year as described in subsection was included.

Subsection (c):

HCJC Policy 115.388 pages 106-108 requires the annual report to be approved by the Agency Head and made available to the public on the department's website. These data were confirmed to be available on the Agency's website.

Subsection (d):

HCJC Policy 115.388 pages 106-108 authorizes the agency to redact certain information as authorized by the standard.

Standard 115.389: Data storage, publication, and destruction

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.389 (a)

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained? ☒ Yes ☐ No

115.389 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.389 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.389 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the 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. HCJC Policy 115.389 pages 108-109
2. Bureau of Justice Statistics Survey of Sexual Victimization, 2019 (completed report)
3. Aggregate Data Presented on the Agency Website https://hayscountytx.com/wpfb-file/prea-statistics_2-xlsx/
4. Interviews with:
a. Agency Head

Findings (By Subsection):

Subsection (a):

HCJC Policy 115.389 requires all sexual abuse and sexual harassment data collected shall be securely retained by the Agency. Data is securely retained in practice.

Subsection (b):

HCJC Policy 115.389 requires the Agency to annually make all aggregated sexual abuse data from the Facility and private contracted facilities readily available to the public through the department's website. These data were present on the website.

Subsection (c):

HCJC Policy 115.389 requires the Facility to remove all personal identifiers on the data before making the aggregated sexual abuse data publicly available. These data were present on the website.

Subsection (d):

HCJC Policy 115.389 requires the agency to maintain sexual abuse data collected for at least ten (10) years after the date of its initial collection. Interviews with the Agency Head indicated these records were stored in compliance with the policy.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard*.) ☒ Yes ☐ No

- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with residents? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Subsection (a):

The facility was audited 3 years ago. The past audit was reviewed as posted on their website.

Subsection (b):

This is the first year of the new three year cycle.

Subsection (h):

The auditor was able to review the facility, records, video, and complete interviews with the full cooperation of the facility.

Subsection (i):

The auditor received all requested materials and files.

Subsection (m):

The auditor was permitted to interview all residents selected at random.

Subsection (n):

Residents were able to confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel; however, to date, no correspondence has been received.

Standard 115.403: Audit contents and findings

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☐ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The onsite PREA Audit was conducted on June 17, 2019, through June 19, 2019. Photographic evidence provided via email from the facility confirmed that the required PREA Audit notice was posted at least 42 days in advance. The photographs confirmed that the notices were posted in various, conspicuous areas throughout the facility. These postings were still in place at the time of the on-site Audit. Careful review of HCJC Policy was completed. To ensure policy was implemented as written interviews with residents, random security staff, a volunteer, mental health staff, intake staff, investigative staff, PREA Coordinator, PREA Compliance Manager, and the Agency head were completed. Additionally, review of video footage was used to verify supervision and rounds.

This Auditor interviewed 10 randomly selected residents and 1 resident selected for specialized interviews at the facility as part of the PREA Audit. Residents were selected form each area of the facility (single cells and Residents reported being informed of the facility's Zero-Tolerance Policy related to sexual abuse and sexual harassment and their right to be free from sexual abuse and sexual harassment as well as their right to be free from retaliation for reporting sexual abuse and/or sexual harassment. Eleven (11) of the 11 residents, or 100%, indicated that they received their PREA Information at their time of intake. All residents reported that they received their PREA Education within 10 days of intake. A later review of 21 randomly-selected files noted that 21 out of 21 current residents (100%) did receive PREA information at their time of intake and all had the required documentation supporting the fact that the residents received their PREA Education within the 10-day timeline. Residents reported receiving the PREA Education one a per month while at the facility in addition to the initial information and education.
During the onsite audit this Auditor talked to security staff, counselors, volunteers, and intake staff. In all, during the onsite audit a total of 15 staff (including employees, volunteers and contractors) were interviewed. Ten (10) of these staff were randomly selected from all shifts and five (5) were specialized staff. Overall, the

staff interviews revealed that staff felt that they had been trained in the PREA standards, their obligations as first-responders, and their respective responsibilities and duties to prevent, detect, and respond to sexual abuse, sexual harassment, and allegations of retaliation for reporting sexual abuse and sexual harassment. The intake staff noted that they have completed a risk factor analysis for each resident to determine proper room and programmatic assignments. This auditor found that the risk factor assessment included all the required elements as per PREA utilizing a questionnaire at intake and the completion of the MAISI Assessment. Review of resident files found three residents who had reported either sexual abuse or committing an act of sexual abuse. Evidence indicates all youth see a counselor within their first week. Of the three residents one only one had been in the facility for more than two weeks. Interviews with the counseling staff found that the youth had been provided counseling with in two weeks of intake and that the need for services regarding the reported abuse was addressed; the facility had created a referral process from intake to mental health for youth responded to past history of sexual abuse or sexually abusive behaviors or offenses.
Through the pre-audit and onsite audit processes, it was determined that 41standards were met an there was no corrective action period needed.

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 resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Joel T. Whitt 7/29/2019

Auditor Signature **Date**

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.