Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Report 04-05-2019

Auditor Information

Name: Will Weir	**Email:** will@preaamerica.com
Company Name: PREA America LLC	
Mailing Address: P. O. Box 1473	**City, State, Zip:** Raton, NM 87740
Telephone: 405-945-1951	**Date of Facility Visit:** 08-13-2018

Agency Information

Name of Agency Bernalillo County Youth Services		**Governing Authority or Parent Agency** *(If Applicable)* Bernalillo County	
Physical Address 5100 2nd Street NW		**City, State, Zip:** Albuquerque; NM 87017	
Mail ing Address: Click or tap here to enter text.		**City, State, Zip:** Click or tap here to enter text.	
Telephone: 505-468-7603		**Is Agency accredited by any organization?** ☒ Yes ☐ No	
The Agency Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☒ County	☐ State	☐ Federal

Agency mission: 1) The mission of the Youth Services Center is to protect the community from those youth placed in its custody. Youth will be detained in a safe, secure, and humane environment in accordance with the American Correctional Association standards. The Center is committed to creating and maintaining alternatives to detention through Community Supervision Programs that promote education, healthy lifestyles, and positive choices for youth and their families. 2) Recognizing that it is not always possible for youth to remain in their home environment, detention services encompass a multitude of services directly related to the protection and care of youth within its jurisdiction. The Center shall administer and deliver programs and services for youth that ensure safe, secure, and humane quality of care and equally promote their well being. Service areas include, but are not limited to: a) Admissions; b) Behavioral health services; c) Medical care; d) Education; e) Recreation; f) Faith-based programs; and g) Community-based programs. 3) The Center shall

possess all the enumerated powers, responsibilities and duties established by the New Mexico Statutes, New Mexico Children, Youth and Families Department Standards, and Bernalillo County.

Agency Website with PREA Information:
https://www.bernco.gov/youth-services-center/prison-rape-elimination-act.aspx

Agency Chief Executive Officer	
Name: Craig Sparks	**Title:** Director
Email: csparks@bernco.gov	**Telephone:** 505-468-7122

Agency-Wide PREA Coordinator	
Name: Gerri (Dupree) Bachicha	**Title:** Juvenile Detention Alternatives Initiative (JDAI) Coordinator
Email: gbachicha@bernco.gov	**Telephone:** 505-468-7603
PREA Coordinator Reports to: Director Craig Sparks	**Number of Compliance Managers who report to the PREA Coordinator** 1

Facility Information

Name of Facility:	Bernalillo County Youth Services Center (BCYSC)			
Physical Address:	5100 2nd Street NW; Albuquerque; NM 87017			
Mailing Address (if different than above):	Click or tap here to enter text.			
Telephone Number:	505-468-7603			
The Facility Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit	
☐ Municipal	☒ County	☐ State	☐ Federal	
Facility Type:	☒ Detention	☐ Correction	☐ Intake	☐ Other

Facility Mission: Same as agency.

Facility Website with PREA Information
https://www.bernco.gov/youth-services-center/prison-rape-elimination-act.aspx

Is this facility accredited by any other organization? ☒ Yes ☐ No

Facility Administrator/Superintendent	
Name: Craig Sparks	**Title:** Director
Email: csparks@bernco.gov	**Telephone:** 505-468-7122

Facility PREA Compliance Manager			
Name:	Jason Ellis	**Title:**	PREA Compliance Manager; Investigator
Email:	jasonelis@bernco.gov	**Telephone:**	505-468-7603
Facility Health Service Administrator			
Name:	Stephanie Medina-Ellis	**Title:**	Nurse Manager
Email:	snellis@bernco.gov	**Telephone:**	505-468-7222
Facility Characteristics			
Designated Facility Capacity:	78	**Current Population of Facility:**	41

Number of residents admitted to facility during the past 12 months	817
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:	431
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:	807
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:	0
Age Range of Population:	11-17
Average length of stay or time under supervision:	20 days
Facility Security Level:	Locked Door and Fenced Facility
Resident Custody Levels:	Pre-Adjudication
Number of staff currently employed by the facility who may have contact with residents:	132
Number of staff hired by the facility during the past 12 months who may have contact with residents:	23
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	133, includes volunteers

Physical Plant			
Number of Buildings:	1	**Number of Single Cell Housing Units:**	5
Number of Multiple Occupancy Cell Housing Units:	0		
Number of Open Bay/Dorm Housing Units:	0		
Number of Segregation Cells (Administrative and Disciplinary:	0		

Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.):

31 cameras assist in supervision in the pods, in visitation, in the gym area, in the transport holding area and intake, as well in perimeter areas, common areas, and other locations.

Medical	
Type of Medical Facility:	24-hour medical care provided
Forensic sexual assault medical exams are conducted at:	New Mexico SANE Unit

Other	
Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:	133
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	9

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.

PREA America LLC was retained 03-27-18 to conduct the PREA Audit of Bernalillo County Youth Services Center (BCYSC). Audit notices were posted around the facility on 06-11-18, and digital proof of these postings was provided to the audit team. The Pre-Audit Questionnaire (PAQ) and supporting documentation on a flash drive were received by the audit team on 06-27-18. Numerous emails were exchanged during the weeks that followed, trying to understand the materials provided and recommending areas of concern for the facility to address. Some materials, such as those pertaining to investigations, were not provided to the audit team until after the on-site audit.

All documents received were reviewed, including logs, training files and curriculum. Background checks, (there were no child abuse registry checks) were randomly selected of staff, contractors and volunteers to verify the initial background check as well as the 5-year recheck requirement. Residents were randomly selected to verify PREA education and PREA Screenings. Phone calls were made to listed advocates, to verify the advocacy required by the standards.

The on-site audit was conducted 08-13-2018 as scheduled. The audit team consisted of DOJ Certified Auditor Will Weir, MCJ, and PREA America Project Manager Tom Kovach. The day started with a briefing, attended by 17 agency leaders. The briefing confirmed current population, agenda and logistics review, discussion of mandatory reporting, and clarifying the need to allow any staff or resident who requests an interview to get one. The audit team checked to see if there were questions or concerns. The Site Review included obtaining and studying the facility diagram of the physical plant. Observing staff and residents and the supervision and movement along with casual conversation to ascertain if observations made were of "normal" supervision and movement. Random checks were

made to assure doors intended to be secured were locked. Random checks of PREA Hotline phones for functionality were made. All housing units and bathroom facilities were inspected for compliance for cross-gender supervision. This included a camera review for those areas with cameras. All areas of the physical plants were observed, with attention to those areas which statistically are high risk for sexual abuse. PREA Postings including third party reporting postings, in the visitation area were checked. Confirmation of the availability to staff of First Responder Duties was also a part of the tour. Blind spots were identified and procedures for checking them were verified.

Interviews were selected in accordance with the guidance of the PREA Auditor Handbook with random selections of residents to ensure diversity of geographic location (from each housing unit), race, and those with risk factors. The facility had difficulty identifying residents who had been screened to have identified risk factors. This indicated a compliance issue with Standards 115.341 and 115.342 which was addressed in the 30 days after the on-site audit. The following interviews of residents were conducted. 11 of 41 residents were interviewed. 3 of these were based on targeted risk factors, according to the instructions in the PREA Auditor Handbook. The other 7 were selected randomly according to the other factors and to make sure residents from every housing unit was interviewed. 3 interviewees were female and 7 were male.

Interviews were in a conversational manner to gain the confidence of those interviewed and to put them at ease so the audit team could better understand their understanding of PREA, and the practices of the facility. Random staff interviews were made to include gender, shift and posting diversity. The following interviews of staff were conducted: agency head designee, agency PREA Coordinator, Superintendent, agency human resources, investigator, PREA Compliance Manager, higher level staff for unannounced rounds, medical, mental health, community Sexual Abuse Nurse Examiner (SANE) by phone, contractor, staff that perform screening and intake, staff who monitor for retaliation and members of the Incident Review Team. Some staff perform multiple functions so were interviewed according to their specialized roles. An additional twelve staff were selected randomly representing various, stations, housing units, shifts and both genders. A total of 21 unique interviews were conducted.

The Exit briefing addressed all aspects of the audit to date. No determination of compliance was given. The recap of the aggregated information obtained and observed was provided and a SWOT (Strengths, Weaknesses, Opportunities, and Threats) briefing was provided by request of the facility staff to assist in furthering the efforts of the facility to prevent and detect sexual abuse and harassment. During the 30 days after the onsite audit, additional emails were exchanged, and additional documentation reviewed. Internet research was done on the facility.

On 09-21-18, an Interim PREA Audit Report was provided to the agency, initiating a Corrective Action Period (CAP) not to exceed 180 days. The activity of the CAP is detailed below in the “Summary of Corrective Action” section.

Documents reviewed include: Pre-Audit Questionnaire; floor plans and facility schematic; facility description; Bernalillo County Youth Services Center (BCYSC) PREA Policy (Policy & Procedure 3.18); BCYSC Administration and Management: General Administration Policy (P&P 1.1); Organizational Chart; https://www.bernco.gov/youth-services-center/prison-rape-elimination-act.aspx; Unannounced Manager Facility Checks; Staff Schedules; Bid positions for probationary and non-probationary staff; BCYSC Sexual Misconduct Policy (P&P 3.20); Participant Sign-In Sheet for May 2017 Transgender/PREA/Directors Forum/Bloodborne Pathogens Training (8 hours); FY17 Employee

Training Calendar; New Hire Training Calendar; Security and Control: Contraband Control, Searches Policy (P&P 3.6); camera locations email; SANE info; documentation regarding forensic exams; BCYSC Medical Department Treatment Protocols for Rape; Staff PREA Training Curriculum; Volunteer/Contractor Curriculum; email reminders to staff regarding policies and procedures; Resident Rights & Well Being; BCYSC Administration and Management: Training and Staff Development Policy (P&P 1.4); Certificates of Completion of training from National Institute of Corrections for PREA: Investigating Sexual Abuse in a Confinement Setting; Certificates of Completion of training from the National Institute of Corrections for PREA: Medical Health Care for Sexual Assault Victims in a Confinement Setting; Certificates of Completion of training from the National Institute of Corrections for PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting; BCYSC Room Confinement/Personal Time-Out and Alert Policy (P&P 3.19); BCYSC Security and Control: Juvenile Discipline Policy (P&P 3.10); BCYSC Security and Control: Gay, Lesbian, Bi-Sexual, Transgender and Questioning Youth Policy (P&P 3.17); BCYSC Security and Control: Juvenile Rights: Grievance Procedures Policy (P&P 3.12); BCYSC Juvenile Services: Mail, Telephone and Visiting Policy (P&P 6.5); BCYSC Juvenile Services: Social Services Policy (P&P 6.2); Annual Reports; Staff Alerts; Memorandum of Understanding Between Bernalillo County and AFSCME Council 18, Local 1536; AFSCME Local 1461 Blue Collar Contract FY-17; and other contracts and MOU's. Documents reviewed during the on-site audit, and/or during the first 30 days thereafter, included investigative files, the updated website, and updated policies. Documents reviewed during the 180-day CAP included additional policy updates; PREA Readiness Team Minutes; email explanations; the 2018 Annual Report; corrected/updated logs; corrective actions; and additional investigative documentation.

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.

The Bernalillo County Youth Services Center (BCYSC) is a secure juvenile detention pre-adjudication facility located in Albuquerque, New Mexico. The 78-bed facility serves male and female detainees ages 11-18 years (currently up to 17) from Bernalillo and several surrounding counties in Central and Western New Mexico. The BCYSC has six units: 4 units with 12 beds, and 2 units with 15 beds. Only 5 Units were in use the day of the on-site audit. The original facility has undergone extensive renovation since opening in 1962. Additional housing units were opened in 1994 and 1996, increasing the capacity to 94. More extensive renovations since 2002 have resulted in the expansion of the healthcare, intake, and master control areas. The one building contains a Gym, Visitation, Booking, Kitchen, Dining room, and a Multipurpose room, with the Laundry area and the housing units. Outdoor recreational areas have also been enhanced, with the addition of the Ropes & Initiative Course and the walking track. Bernalillo County has a maintenance area in the same building but separate from the Detention Center's maintenance shop. The Detention Center is attached to the County's Juvenile Court Division Building, which also houses state Probation officers. There is a separate entrance for the detention center. There is also a sally port gate, where law enforcement brings juvenile offenders for intake purposes. Cameras are present to supplement supervision. Blind spots have been identified, and cameras, mirrors, and heightened staff attention are used to mitigate those areas.

Summary of Audit Findings

*The summary should include the number of standards exceeded, number of standards met, and number of standards not met, **along with a list of each of the standards in each category**. If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance.*

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

Number of Standards Exceeded: 0

Number of Standards Met: 43

Number of Standards Not Met: 0

Summary of Corrective Action (if any)

Bernalillo County Youth Services Center (BCYSC) shows full compliance with all the PREA Standards. However, at the time of the Interim Report (09-21-2018) there were 9 Standards with which the facility had not yet shown compliance. These Standards, and summaries of corrective actions taken, are provided here:

Standard 115.311: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
At the time of the Interim Report, the agency had not shown that practices associated with PREA Coordination had been in place to cover all parts of PREA in the facility. Also, they had not shown that the PREA Coordinator had the authority to coordinate the facility's efforts to comply with PREA standards. During the CAP, PREA Investigations Policy was changed to outline PREA Coordinator Authority and duties in the course of investigations. A PREA Readiness Team was formed, which has been facilitated under the PREA Coordinator's direction since November 2018. Monthly PREA Readiness Team notes were provided to the auditor, along with the PREA Training activities schedule. The PREA Coordinator provided the annual PREA Report and provided verification of the other items of the CAP, as evidence of the PREA Coordinator's authority and for compliance with Standard 115.311. This includes the review of every alleged allegation of sexual abuse and harassment. The agency has shown that practices associated with PREA Coordination are now in place to cover all parts of PREA in the facility. BCYSC has shown, in active practice, since December 2018, that the PREA Coordinator has authority to coordinate the facility's efforts to comply with the PREA standards.

Standard 115.317: Hiring and promotion decisions
At the time of the Interim Report, the facility did not show compliance with number 2 under sub-section c, nor with subsection d, because they did not check the New Mexico equivalent of a child abuse registry. BCYSC obtained legal assistance, researched the law, and evaluated their options. During the CAP they secured a court order to have access to the information required for compliance with this standard from the Children, Youth & Families Department (CYFD). This order did not come through until near the end of the CAP. The auditor has verified with Greg Nelson, Bureau Chief of Juvenile

Justice Services Performance/Policy for CYFD, that processes and procedures, are to be followed, not only for BCYSC, but for other applicable facilities around the state.

Standard 115.322: Policies to ensure referrals of allegations for investigations
At the time of the Interim Report, the agency still needed to show documented proof that investigations have been completed, in practice, on all complaints that allege or suspect sexual harassment or sexual abuse. During the CAP, the agency completely revised their logging and tracking system and reviewed every investigation, doing additional investigative work when needed. The agency has provided proof that investigations are completed, in practice, on all complaints that allege or suspect sexual harassment or sexual abuse.

Standard 115.334: Specialized training: Investigations
At the time of the Interim Report, since investigations had not been completed and documented appropriately, it seemed clear the agency had not shown that training had been sufficient for the needs of the facility investigators, as required in sub-section (a) of this standard, and by the agency's own policy. During the CAP, the investigators completed additional training, and they also provided additional proof of relevant prior training. In addition to what was required in the CAP, BCYSC engaged a teamwork approach to revise their investigation format and their investigations policy, as well as all the investigations completed in the past 12 months, making sure to include all elements required by this standard, with oversight. In some cases, they conducted new interviews. In other cases, they included information which they already had, but which they had not previously included in the file. They rewrote narratives for clarity. The established policy and the updated policy, combined with the new investigative format, and the actual investigations provided, which are fully consistent with the training and standards, collectively resolve compliance issues identified in the Interim Report.

Standard 115.367: Agency protection against retaliation
At the time of the Interim Report, policy related to this standard had been verified, but the facility still needed to show compliance with this standard in practice. During the CAP, the Retaliation Form was updated and found to be compliant with the standard. It is worded to be helpful in prompting the user to check for retaliation in all the ways required in the sub-sections of this standard. Retaliation Monitoring was a standing agenda item for the PREA Readiness Team and was discussed regarding retaliation against a youth who had reported a grievance/incident. The audit team received documentation of retaliation monitoring for all applicable investigations.

Standard 115.371: Criminal and administrative agency investigations
At the time of the Interim Report, policy related to this standard had been verified, but the facility still needed to show proof of practice. During the CAP, updated investigations and related policies and procedures were provided to the audit team and were compliant with the standard.

Standard 115.373: Reporting to residents
At the time of the Interim Report, investigative materials reviewed did not indicate the residents were receiving information, applicable to this standard, that was based on a full review (or investigation) of the circumstances surrounding the incident. It appeared that some were asked to sign a "Major Incident" form, while some were told something verbally, while others may not have been told anything regarding a finding. During the CAP, the agency developed new notification letter templates. A helpful feature of these templates is providing removable verbiage, which assists the administrator who notifies the resident to follow all sub-sections of this standard, and which facilitates documenting the notifications. This template has been reviewed by the agency PREA Team, approved, distributed, and implemented for use. A review of all investigations indicates all notifications have been done as per the minimum requirements of this standard.

Standard 115.387: Data collection
Although the facility had been keeping logs, documenting responses, and performing Incident Reviews, a problem at the time of the Interim Report was that the agency had not been keeping track of sexual misconduct in a way differentiating between sexual harassment, sexual abuse, and rule violations. A number of alleged rule violations, such as teens making vulgar noises or talking about sexual activities, were included in a broad “PREA” category. During the CAP, the agency developed, tested, and implemented a new sexual abuse and sexual harassment data log and tracking system. They wrote their 2018 Annual Report. By the end of the CAP, the agency has demonstrated that it collects accurate, uniform data for every allegation of sexual abuse, using a standardized instrument and set of definitions; and writes an annual report. The agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

Standard 115.388: Data review for corrective action
BCYSC PREA Policy is consistent with the standard, stating that “The Director or Designee will maintain a tracking system that records all allegations of sexual misconduct and their disposition. The Director or Designee will maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files and sexual abuse incident reviews. The incident-based data collected will be aggregated at least annually and will include, at a minimum, the data necessary to answer all questions from the most recent survey of the Survey of Sexual Violence conducted by the Department of Justice”. The problem at the time of the Interim Report was that the agency had not been keeping track of sexual misconduct in a way that differentiated between sexual harassment, sexual abuse, and rule violations. A number of alleged rule violations, such as teens making vulgar noises, or randomly referencing sexual activities or body parts, were included in a broad “PREA” category, yet no investigations had been conducted, according to the PAQ. Putting all sexual harassment and sexual abuse under the same umbrella as all sexual misconduct and rule violations, then not conducting any investigations, made it impossible to gather and review the data for corrective action as required by the Standard. During the CAP, the PREA Review Team continued to meet under the direction and facilitation of the PREA Coordinator. The team reviewed the findings from the investigations of every allegation of sexual abuse and harassment. The allegations were sorted out and logged according to the Standard, and in a way that collected the information needed for the Survey of Sexual Victimization, and provided to the audit team, along with documentation of corrective actions. At the end of the CAP, the agency has shown policy and practice consistent with the standard. They have verified this through an expanded and improved system of logging and tracking complaints, data collection, and corrective actions.

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.

This standard is covered in BCYSC PREA Policy & Procedure # 3.18, effective August 13, 2013. At the time of the audit, however, the organizational chart did not show the PREA Coordinator to have oversight over the facility. Instead, the PREA Coordinator was in charge of the agency's community operations. During interviews and emails, the PREA Coordinator and other administrators spoke of required changes that were planned during the previous PREA audit, which were only recently being

implemented. There appeared to be gaps in PREA oversight and coordination in actual practice. For example, investigation tracking forms were in place and being used, as well as follow up PREA incident reviews; but the investigations themselves were not shown to have been reviewed for PREA compliance. A new Organizational Chart was completed during the 30 days after the on-site audit.

Corrective Action: During the CAP, PREA Investigations Policy was changed to outline PREA Coordinator Authority and duties in the course of investigations. A PREA Readiness Team was formed and has been facilitated under the PREA Coordinator's direction since November 2018. Monthly PREA Readiness Team notes were provided to the auditor, along with the PREA Training activities schedule. The PREA Coordinator provided the annual PREA Report and provided verification of the other items of the CAP, as evidence of the PREA Coordinator's authority and for compliance with Standard 115.311. This includes the review of every allegation of sexual abuse and harassment.

Analysis: The agency has shown that practices associated with PREA Coordination are now in place to cover all parts of PREA in the facility. Also, they have shown, in active practice, since December 2018, that the PREA Coordinator has authority to coordinate the facility's efforts to comply with PREA standards. Policies and documentation are referenced above, and in narratives in this report regarding the resolution of the items addressed in the CAP.

Finding: The agency has shown full compliance with all sub-sections of this standard.

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 OR the response to 115.312(a)-1 is "NO".) ☐ 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 agency has not entered into contracts for the confinement of residents since the previous audit. The agency houses residents for other agencies, but it does not contract for other agencies to house BCYSC residents. An exception might be for treatment purposes, but those facilities do not primarily house youth that are in the justice system; so, those facilities are exempted from PREA standards.

Analysis: When an agency or facility shows that a standard does not apply, the agency/facility is not considered to be in violation of the standard.

Finding: The facility has shown compliance with this 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 agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

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

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

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: 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 only until October 1, 2017.)
  ☒ 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 only until October 1, 2017.)
  ☒ 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 only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.) ☒ 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.

PREA Policy & Proc.# 3.18, Effective Date: August 13, 2013, and Sexual Misconduct Policy & Proc.#: 3.20, Effective Date: May 14, 2014, require adequate supervision of youth, as well as of staff. Documentation of compliance with this standard also involved reviewing documentation of unannounced supervisory rounds, staff schedules, daily population reports, emails to supervisors, and the Staffing Plan. Interviews with all the administrators indicated full recognition of this PREA Standard, as well as of the New Mexico Counties; and of the Children, Youth and Families Department staffing rules for juvenile facilities. The facility has been operating under a set of staffing plans and guidelines that accounted for all parts of this standard, but which were not written up in the format recently recommended in by the PREA Resource Center (PRC). The agency reviewed their staffing practices and compiled these into the recommended PRC plan format during the audit process.

Analysis: All sub-sections of this standard have been in practice for more than 12 months, according to all facility administrators interviewed. Documentation also verifies this, but the staffing plan format has been recently changed and improved to align to nationwide staffing documentation practices recommended by the PRC.

Finding: The agency has shown compliance with all parts of this standard.

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 implement policies and 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.

Security and Control: Contraband Control, Searches Policy and Proc.# 3.6 Effective Date: November 1, 2010, revised 2014, was reviewed to verify that current policies conform to this standard. Other documentation reviewed included annual training, new employee training, employee signature acknowledgements of training, training schedules, and the PAQ. Documentation of searches is adequate to track deviations from policies. For example, there were 3 searches of transgender residents conducted according to policy and standard. The facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. This policy is known by staff, and documentation is maintained showing that searches are only done when necessary and are done according to policy. Interview guides used by the audit team, for both staff and residents, ask questions that assist in determining whether the facility follows this standard in practice. No answers indicated violations of this standard.

Analysis: A triangulation of evidence from formalized policies (including training), in-depth interviews with both staff and youth, and documentation of practice, combine to indicate full compliance with this standard at BCYSC.

Finding: The facility has shown compliance with this standard.

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.

PREA Policy & Proc.# 3.18, Effective Date: August 13, 2013, and Sexual Misconduct Policy & Proc.#: 3.20, Effective Date: May 14, 2014, cover these sub-standards. The Pre-Audit information from the agency stated, "Our behavioral health services, medical services, as well as operations staff work closely with youth that have physical disabilities, cognitive or intellectual disabilities, psychiatric disabilities, and or sensory disabilities. We utilize assistive devices and or assistive technology such as TTY devices as well as the use of interpreters." During the on-site audit, staff were asked how to access these services, and they indicated that either they knew whom to ask, or they knew how to use the equipment/system themselves. They verbalized a desire to help residents in any way they can. Since the facility had not been able to identity residents with disabilities, impairments, of limited proficiencies for the auditor to interview, the auditor asked the residents who were interviewed whether they believed the facility would provide the help such residents might need. Although most of the 10 interviewed residents indicated that they trust staff to do the right thing, 3 residents stated they felt that staff are not always wise or appropriate in their dealing with residents who have challenges.

Analysis: Policies reviewed, along with documentation of practice, are consistent with interviews that attest to the facility's ability to assure residents can participate in, or benefit from, all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

Finding: The facility shows substantial compliance. It complies in all material ways with the standard for the relevant review period.

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, or 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)

- Unless prohibited by law, 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.

BCYSC PREA Policy and Procedure #3.18 accommodates this standard. Ten files were pulled randomly to verify compliance with this standard, and they had required documentation except for the child abuse check. BCYSC requires and monitors that criminal background checks are completed, but, at the time of the Interim Report, the facility did not show compliance with number 2 under sub-section c, nor with subsection d, because they did not check the New Mexico equivalent of a child abuse registry. BCYSC obtained legal assistance, researched the law, and evaluated their options. During the CAP, they, without objection from the Children, Youth & Families Department (CYFD), secured a court order to have access to the information required for compliance with this standard. This Order did not come through until near the end of the CAP. The auditor has verified with Greg Nelson, Bureau Chief of Juvenile Justice Services Performance/Policy for CYFD, that processes and procedures are to be followed, not only for BCYSC, but for other applicable facilities around the state.

Corrective Action: The agency conducted research into New Mexico Statutes and the federal Prison Rape Elimination Act (PREA) and secured a Court Order to be able to consult the child abuse records maintained by the State as required by this standard.

Analysis: BCYSC PREA Policy and Procedure #3.18 accommodates this standard. Ten files were pulled randomly to verify compliance with this standard, and they had required documentation except for the child abuse check. During the CAP, the agency fulfilled the requirements of the CAP and are now checking the New Mexico equivalent of a child abuse registry. The 180-day CAP expired before actual verification of these checks could be provided, but the auditor verified with administrators at both CYFD and BCYSC that this process has begun. Protocols are in place to assure that CYFD's records regarding child abuse are being checked regarding all BCYSC employees and applicants from now on.

Finding: The agency shows full compliance with this standard.

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.

BCYSC has not acquired a new confinement facility nor made a substantial expansion or modification to existing facilities since August 20, 2012. The facility has, however, installed a video monitoring system. The auditor was familiarized with this system during the facility tour, and it was discussed during interviews. The safety of residents was considered at the time of the update. They can directly

supervise residents through line-of-sight, as well as through monitoring camera perspectives. The upgrades have been documented by the facility as follows: An installation of 25 IP Cameras was completed on 11/25/13, upgrading the cameras in the pods. An installation of 1 IP Camera in visitation was competed on 7/31/14. An installation of 2 IP Cameras in the gym area was competed on 9/30/14. An installation of 2 IP cameras in the transport holding area was completed in 2016. An installation of 1 IP Camera in intake was completed on 1/2/18. A total of 31 IP cameras were installed and operational, since 8/20/12.

Analysis: Compliance with this standard was verified via documentation reviewed; and, in person by the audit team during the site review; and, during interviews conducted by the audit team during the audit.

Finding: The agency has shown compliance with this standard.

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? ☒ Yes ☐ No

- 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 entity 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? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.) ☒ 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.

BCYSC PREA Policy and Procedure #:3.18 accommodates this standard, as does the Coordinated Response Plan. It is not uncommon for residents at BCYSC to be survivors of sexual assaults that occurred prior to incarceration. The BCYSC Medical Department sees a number of residents who have made disclosures and need care. The auditor reviewed documentation of three such cases that required forensic examination. BCYSC protocols are strict, clear, and compassionate. The following is an excerpt with formatting removed: "All clothing, towels, belongings must accompany the resident to the SANE or ER evaluation. Bag any items that are not currently being worn or have been used by the resident and send them to the designated evaluation location as well. THE CHAIN OF EVIDENCE IS OF UTMOST IMPORTANCE SECONDARY ONLY [TO] THE HEALTH AND WELL BEING OF THE RESIDENT. Be [as] emotionally and physically supportive as the resident requires and as is appropriate. Be very cautious if there is a medical need to touch the resident, ask permission before you proceed, respecting their wishes. Speak to the individual in a soft yet factual manner. Avoid loud voices, condescending, demeaning or threatening comments. Provide simple directions and be patient. As possible, any type of physical restraint should be avoided as this may trigger feelings of extreme fear." Interviews with members of community organizations on the Sexual Abuse Response Team (SART) verify the facility's professionalism in providing care in cases of which they are aware.

Analysis: Written policy and procedures that have been followed in cases requiring forensic examinations (although the assaults happened prior to incarceration), along with interviews with administrators in BCYSC and in the community, verify compliance with this standard.

Finding: BCYSC has demonstrated compliance with this standard.

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 such publication 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.

Although clearly required by BCYSC policy, at the time of the Interim Report, the agency had not shown that it had fully investigated the complaints and referrals received. The agency provided the content of files they had maintained. In addition, they have shown strict adherence to confidentiality guidelines, both by documenting confidentiality requirements in each file, and by storing each file under lock and key, in an office with very limited and controlled access. These files contained investigative documentation, which included complaints and a tracking report, indicating a summary of how they investigated the complaint. However, at that time, the auditor did not find any document, or set of documents, that was labeled “investigation” or that contained the minimum ingredients of a full and complete sexual abuse/harassment investigation. Adding to the complexity of the situation is that some of these files appeared to contain rule violations, or adolescent behaviors such as making inappropriate noises, that did not state that sexual abuse or sexual harassment was suspected by anyone documenting or reporting the occurrence. Interviews with administrators indicated the agency was trying to track any and all complaints that might have been of a sexual nature, out of an abundance of caution. Since some of these complaints did indicate suspicions of sexual harassment, or behaviors that would fit the definition of sexual harassment if true (none alleged abuse), additional investigative documentation was required in order to show full compliance with this Standard in those cases.

Corrective Action: During the CAP, the agency completely revised their logging and tracking system and reviewed every investigation, doing additional investigative work when needed.

Analysis: The agency has provided proof that investigations have now been completed, in practice, on all complaints that allege or suspect sexual harassment or sexual abuse. Their policies and practices match the standards.

Finding: The agency has shown full compliance with this standard.

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.

BCYSC provided training curriculum and employee training acknowledgements to show that all employees who may have contact with residents have been trained on the matters required for this standard. Between trainings, the agency provides employees who may have contact with residents with refresher information about current policies regarding sexual abuse and sexual harassment and documents this training. Training curriculum appears consistent with agency policy, as well as with this PREA Standard. Interviews with staff also indicate they remember receiving the training and that they have retained the training well.

Analysis: Since the training and policy documentation match the PREA Standard, and since employees demonstrate an understanding of these topics during interviews, the agency has shown compliance.

Finding: The agency complies in all material ways with this standard for the relevant review period.

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.

According to curriculum and documentation provided, volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. The level and type of training provided to volunteers and contractors is based on the services they provide and the level of contact they have with residents. They have all been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment, and they have all been informed how to report such incidents. The agency maintains documentation confirming that volunteers/contractors understand the training they have received. Due to some policy updates completed during the course of this audit, some training materials were also updated. Therefore, volunteers were recently retrained to make sure they have the latest and most accurate information. Training signature sheets, and the curriculum, were provided by BCYCS and reviewed by the auditor. Also, the audit team interviewed the administrators who train and supervise volunteers.

Analysis: Since the training matches the agency PREA policy as well as the PREA standards, and since the interviews conducted provide verification that the volunteer program complies with PREA, it appears the agency has shown full compliance with this standard.

Finding: The facility complies in all material ways with this standard for the relevant review period.

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 such education? ☒ 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.

BCYSC PREA Policy and Procedure #:3.18, as previously mentioned, supports this standard. Sexual Misconduct Policy & Proc.# 3.20 Effective Date: May 14,2014 specifically requires resident PREA education as required in this standard. Also training materials, postings around the facility, and handouts such as Resident Rights & Well Being and Rules and Responsibilities support the education provided, and they serve to remind residents of their right to be safe from sexual abuse. Documentation, such as the residents' Acknowledgement of PREA Education, also helps to verify that the residents received this education. 8 of the 11 residents interviewed remember the education provided when they arrived at the facility. It should be noted that, unlike correctional facilities that

provide post-adjudication care, BCYSC admits youth from off the street who may be currently undergoing crisis and who might not have slept recently, or who might only recently have been cleared medically after intoxication and drug abuse; so, these residents might not remember the details of the booking process. The agency provides resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills. Information received during the pre-audit process, as well as during the on-site audit and site review, including interviews with staff and residents, generally indicate that the residents understand the zero-tolerance policy and various ways to report.

Analysis: The agency policy is consistent with this PREA standard regarding about what residents should be informed. Documentation regarding what information is provided to residents matches what the overwhelming majority of residents acknowledge they receive.

Finding: The facility shows compliance in all material ways with this standard for the relevant review period.

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.

BSYSC Administration and Management: Training and Staff Development Policy Proc. #:1.4, Effective November 1, 2010, states in Section 2 (c): "Specialized training is provided for the PREA Coordinator, investigators, victim support persons and other personnel who respond to incidents of sexual misconduct. This training includes facility policy, crime scene management, elimination of contamination, evidence collection protocol for confinement settings, techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, and crisis intervention." At the time of the Interim PREA Audit Report, it appeared that since investigations had not been completed and documented appropriately, the agency had not shown that training had been sufficient for the needs of the facility investigators, as required in sub-section (a) of this standard, or by the agency's own policy. The investigators had completed "PREA: Investigating Sexual Abuse in a Confinement Setting," but it was not clear what other background or training they had that could assist and support their efforts to complete quality investigations.

Corrective Action: The investigators completed additional training, and they also provided additional proof of relevant prior training. In addition to what was required in the CAP, BCYSC engaged a teamwork approach to revise their investigation format and their investigations policy, as well as all the investigations completed in the past 12 months, making sure to include all elements required by this standard. In some cases, they conducted new interviews, and in other cases, they included information they already had but had not previously included. They rewrote narratives for clarity.

Analysis: The amalgamation of the established policy and the updated policy, combined with the new investigative format, and combined with actual investigations provided which are fully consistent with the training and standards, resolves all compliance issues identified in the Interim Report.

Finding: The agency is fully compliant with this standard.

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? ☒ Yes ☐ No

- 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? ☒ Yes ☐ No

- 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? ☒ Yes ☐ No

- 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? ☒ Yes ☐ No

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.) ☐ 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? ☒ Yes ☐ No

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? ☒ Yes ☐ No

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? ☒ 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.

Administration and Management: Training and Staff Development Policy & Proc. # 1.4, Effective: November 2010, also applies to medical and mental health staff. The Policy states, "Specialized Training for Medical and Mental Healthcare Personnel. All medical and mental healthcare practitioners who work regularly in the facility, regardless of their status as employees of the facility or contractors, shall be trained in:

i) How to detect and assess signs of sexual abuse and sexual harassment;
ii) How to preserve physical evidence of sexual abuse;
iii) How to respond effectively and professionally to victims of sexual abuse and sexual harassment; and
iv) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment.
3) Specialized training can be accomplished via the National institute of Corrections website located under the sections of e learning PREA.
4) All Youth Program Officers, Professional Specialist Employees, and Case Managers shall receive an additional forty (40) hours of training each subsequent year after their first year of employment to include, but not limited to:
a) Security/Safety/Fire/Medical/Emergency Procedures;
b) Supervision of Offenders;
c) Use of Force;
d) Certified Course in Restraint Training;
e) Standard of Conduct;
f) Sexual Abuse/Assault intervention;
g) Code of Ethics;
h) Additional topics shall be included based upon a needs assessment of both staff and Center requirements.
5) Professional specialist employees shall also meet their continuing education credit requirements as needed to maintain professional licensing."
In addition to receiving this training, medical and mental health professionals at the facility also document their work in a way that indicates application of this training in practice. Interviews with youth and staff provided no evidence contrary compliance with this standard. These residents and staff indicate confidence in the facility's ability to provide appropriate care to those who need it.

Analysis: Policy, training, interviews, and documentation of practice provide verification of compliance.

Finding: The facility has shown compliance with this 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: Prior sexual victimization or abusiveness? ☒ Yes ☐ No

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

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

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

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

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

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

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

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

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: 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.

BCYSC PREA Policy and Procedure #:3.18, as previously mentioned, supports this standard. Sexual Misconduct Policy & Proc.# 3.20 Effective Date: May 14, 2014 specifically requires resident screening for risk of victimization and abusiveness, as required in this standard. At the beginning of the pre-audit process, the facility was using a combination of a number of screening instruments, in order to collect the information, but the information was not available to all the administrators who needed it to make decisions, as required by this standard and by Standard 115.342. This was made clear when the PREA Compliance Manager was unable to access this information for the on-site audit when the audit team needed to select residents for targeted interviews. 2 residents of 11 did not remember being screened, and one remembered being screened by computer, rather than by interview as required. The facility immediately tackled this problem: They developed a screening tool to guide the screener regarding where to look in the mental and physical health assessments, court records, and other sources of information, so as to have all the screening information together in one place, so that dependable risk assessments could be made uniformly. They also provided professional guidance to screeners regarding interviewing residents in such a way as to collect as much information as possible, sensitively and confidentially. The facility informed the staff of the updates, implemented the changes, and provided the audit team with documentation and an example of practice.

Analysis: Interviews, policy, and documentation of screenings have shown minimum compliance with all sub-standards of this standard.

Finding: The facility has shown compliance in all material ways with this standard.

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? ☒ Yes ☐ No

- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? ☒ Yes ☐ No

- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? ☒ Yes ☐ No

- Do residents in isolation receive daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- Do residents also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.342 (c)

- Does the agency always refrain from placing: Lesbian, gay, and bisexual 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 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 paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?) ☒ Yes ☐ No ☐ NA

- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?) ☒ 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? ☒ 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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Sexual Misconduct Policy and Procedure #320, Effective Date: May 14,2014; Room Confinement/ Personal Time-Out and Alert Policy & Proc. 3.19, Effective Date: November 25, 2013; Security and Control: Juvenile Discipline Policy & Proc.#: 3.10, Effective Date: November 1, 2010; and Security and Control: Gay, Lesbian, Bisexual, Transgender and Questioning Youth Policy & Proc.#:3.17 Effective Date: April 1, 2011, all apply to the practice of this standard. As mentioned above, at the time of the audit it appeared that this information had not been shared adequately for housing, work, bed, education, and programming assignments to be made. The PREA Compliance Manager said the information was not available outside of the Behavioral Health Department. This was corrected during the 30 days after the on-site audit, and verification was provided to the audit team.

Analysis: Policy, documentation of practice, and recent acknowledgements of updates in practice, provide credibility to the idea that the facility is compliant with this standard.

Finding: The facility has shown full compliance with this standard.

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? ☒ Yes ☐ No

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.

BCYSC PREA Policy and Procedure #:3.18, also applies to this standard, along with Security and Control: Juvenile Rights: Grievance Procedures Policy and Procedure 3.12, Effective 10-01-2010. Options for resident reporting are evident, not only in policy, but on the site review and in the resident handbook. Residents acknowledge this in writing during resident education, and (when interviewed about it), 9 out of 11 residents remembered this education being provided soon after their arrival at the facility.

Analysis: The facility shows compliance through policy, through notices that are posted around the facility, and through acknowledgements from residents. Also, the auditor reviewed reports that have been made by residents and forwarded to investigators.

Finding: The facility shows compliance in all material ways with this standard for the relevant review period.

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 ☐ NA

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.

The auditor reviewed Security and Control: Juvenile Rights: Grievance Procedures Policy and Procedure 3.12, Effective 10-01-2010. In addition, policy relevant to this standard is also found in Sexual Misconduct Policy & Proc.#: 3.20, Effective Date: May 14,2014. The audit team reviewed training curriculum wherein both youth and staff are taught about the grievance process. They acknowledge knowing how to utilize this process during interviews. The auditor reviewed grievances that have been filed which appear to be in keeping with this policy and standard.

Analysis: Agency grievance policy is taught to residents and staff. They are provided access and opportunities to utilize this process. This was verified during the site review and during interviews, as well as through reviewing grievances residents have filed.

Finding: The facility has shown compliance with this standard.

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? ☒ Yes ☐ No

- 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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BCYSC PREA Policy and Procedure #:3.18, also applies to this standard, along with Juvenile Services: Mail, Telephone and Visiting Policy & Proc.#: 6.5, Effective November 1, 2010. Initially the facility provided the audit team with documented efforts to enter into an MOU with the Rape Crisis Center. The Rape Crisis Center is contacted by the SANE Collaborative when there is a need for a forensic exam, according to Kelly Shelton, PREA Advocate at the Rape Crisis Center, interviewed by the auditor on 07-18-2018. At the time of that interview, they did not have an MOU with BCYSC and did not receive referrals directly from them. The Rape Crisis Center has an MOU with the Bernalillo County Adult Detention Center and is active with them, including attending Sexual Abuse Response Team meetings there that are also attended by the Sheriff's Department. Advocates from the Rape Crisis Center have received referrals, via the SANE Collaborative, regarding residents at BCYSC who were assaulted in the community. BCYSC worked well with them, providing them confidential access to their clients at the facility. Ms. Shelton's contact at BCYSC has been Director Craig Sparks. Last September advocates went to the facility and provided presentations in each pod, attended by staff and residents. During the audit process, the facility finalized and implemented their Memorandum of Understanding with the Rape Crisis Hotline.

Analysis: Policies cover all sub-standards of this standard and are re-enforced through an MOU and training with community agencies, and by participation in the Sexual Abuse Response Team (SART).

Finding: The facility has shown compliance with this standard.

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

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Notices posted at BCYSC state, "Your child has the right to be safe and to be treated fairly while detained at the Bernalillo County Youth Services Center; regardless of race, religion, national origin (what country you or your family came from), disability, gender or sexual orientation. If anyone is alleged to have called your child names, threatened your child, or is alleged to have hurt your child you may file a complaint/grievance form and you may call the Grievance Hot Line for the Youth Services Center at 505-468-7708." This is in addition to materials provided to parents, including the Parent Handbook, regarding their right to contact the Children Youth and Families Department (CYFD), and other PREA postings placed around the facility. Such information is also available on the website. Nearly all residents interviewed were immediately able to verbalize their understanding that having someone, such as a family member, report is a legitimate method of reporting sexual abuse or other complaints. Staff interviewed understand their responsibility to assist third-party reporting when they have the opportunity. Postings were updated during the audit process to make it abundantly clear which numbers are for Rape Crisis intervention/advocacy and which are for reporting.

Analysis: The information provided to the residents and their families is consistent with this PREA Standard and agency policy. In addition, when complaints are made, they are handled with confidentiality and provided to agency investigators or grievance counselors as appropriate.

Finding: The facility has shown compliance with this standard.

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 the 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? (N/A if the alleged victim is not under the guardianship of the child welfare system.) ☒ Yes ☐ No ☐ NA

- 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.

Policy for this standard is found in BCYSC PREA Policy and Procedure #:3.18. 13.18.1 states, "A. Reporting and investigation: 1. All staff members and volunteers have an affirmative duty to immediately report any knowledge, suspicion, or information regarding sexual misconduct involving a youth." Later, in Part D, it goes on to explain, "Staff must comply with mandatory child abuse reporting laws. All incidents of sexual abuse and situations in which staff knew of sexual abuse and failed to take reasonable steps to prevent must be reported to the New Mexico Children Youth and Families Department (CYFD). Confidentiality must also be preserved. Apart from reporting to the Director or

Designee and CYFD, staff are prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions." The reports that were received during the 12 months prior to the on-site audit were reviewed by the audit team and lend credibility to the fact that the facility actively takes reports and tries to process them as required. The reports document notifications to CYFD, parents, and others as required. Interviews with staff and youth also confirm that reports can be made, and that they will be taken seriously, and that confidentiality is protected appropriately.

Analysis: Evidence that policy is being followed in practice is documented in the written reports of suspicions and allegations of sexual abuse or harassment that have been taken and logged by the agency. Additional confirmation of compliance with this standard is obtained in verbal interviews with random staff and residents.

Finding: The facility has shown compliance with this standard.

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.

BCYSC PREA Policy and Procedure #:3.18 requires the agency to protect any resident who is subject to a substantial risk of imminent sexual abuse and to protect the resident. The training curriculum also instructs staff regarding what to do when residents may be in danger. The PAQ states no residents have been identified in the past 12 months as being subject to substantial risk of abuse. Interviews with staff and residents indicate a belief that residents will be protected. Residents provide examples of times when staff have been responsive to their needs, although it was not an emergency. They also

indicate they know of no times when a peer was left in an unsafe circumstance. Staff verbalize the steps they would take to protect residents.

Analysis: Policy is clear, and no violations of this standard came to light during the audit. Staff understand the policy and the training they have received, and the youth generally feel safe, indicating they believe staff can and will protect them.

Finding: The facility has shown compliance with this standard.

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.

BCYSC PREA Policy and Procedure #:3.18 requires the agency to report to other facilities and to take reports from other facilities. The auditor reviewed a report taken at BCYSC from a BCYSC resident regarding an alleged sexual assault that allegedly occurred at a different facility. The documentation indicated that this standard was followed closely, although the facility where the incident occurred may have been a treatment facility rather than a confinement facility. Policy states in Section G, "Reportinq to Other Confinement Facilities: 1. Upon receiving an allegation that a juvenile was sexually abused while confined at another facility, the Director or Designee will notify the Administrator of the facility where the alleged abuse occurred and will also notify CYFD. Such notification will be provided as soon as possible, but no later than 72 hours after receiving the allegation. The Director or Designee will document that he or she has provided such notification. Interviews with administrators indicate they are aware of the report referenced above and know the procedure to follow, should such a report come in again. They also know what to do if a report comes in from another facility about one of their former residents.

Analysis: Policy, documentation, and practice of this standard were verified through a report reviewed by the auditor. Interviews surrounding this report also added collateral evidence that this policy and standard are understood at this facility.

Finding: This facility has shown compliance with this standard.

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.

Initially, the policy and first responder duties provided for the auditor to review seemed to leave out the suspected perpetrator in some circumstances, as if he or she would not be a source of forensic evidence. Several interviews with staff also indicated that they did not understand their first responder duties very well. This possible oversight was quickly addressed, and policy was changed to clarify the language, and staff were retrained on these duties. The audit team was provided documentation of the retraining, staff acknowledgments, and new postings that went up in areas where staff can see and review the First Responder Duties. Investigations reviewed indicated that First Responder duties have been followed as per policy and standard.

Analysis: Policy was improved to make duties clear, and additional trainings implemented the changes during the pre-audit work and in the 30 days after the on-site audit. Investigations indicate this standard is being followed in practice.

Finding: The facility has shown compliance with this standard.

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

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The Coordinated Response Plan (CRP) initially reviewed, early in the Pre-Audit phase, seemed to have the minimum information required by the standard. However, it was not available widely throughout the facility, but kept back in Medical. The plan has since been expanded through the process of improving the wording of the First Responder Duties and through the adding of the MOU and specific roles for the Rape Crisis Center. Also, the CRP profile has been expanded, and it has been made available in every unit throughout the facility. It should be noted that when the auditor reviewed allegations/suspicions of sexual abuse or sexual harassment, the protocols appear to have been followed appropriately, both before and after the plan was improved and given higher visibility.

Analysis: Documentation of protocols that need to be followed appear to be supported by practice. Improvements made in the wording of the first responder duties, as well as the MOU with the Rape Crisis Center, and the distribution of the document to all units in the facility, appear to make the document more useful to the staff. It is easier to follow and understand, and it is also easier to locate. This standard was not part of the CAP because all corrections were made prior to the audit and in the 30 days after the on-site audit.

Finding: The facility has shown compliance with this standard.

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

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AFSCME Local 1461 Blue Collar Contract FY-17; Memorandum of Understanding Between Bernalillo and AFSCME Council 18, Local 1536, Regarding Pay Grade Adjustment for YPO I and YPO II; and AFSCME Council 18, Local 1536, YSC Contract 2017-2020 were reviewed. The agency retains the ability to protect victims from abusers.

Analysis: The wording of the contracts, and the interpretation of administrators, seem consistent with this standard, so the agency can act on behalf of alleged victims to keep them safe.

Finding: The facility has shown compliance with this standard.

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 for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, 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? ☒ 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.

During the audit, the agency worked to improve their retaliation monitoring policies and procedures, by assigning duties and by specifying which forms to use. However, at the time of the Interim Report, there was still the matter of allegations that were yet to be fully investigated, and which might have indicated or included allegations of retaliation or required monitoring for retaliation. Mandatory retaliation training was on September 5th, 2018, within the 30 days after the on-site audit.

Corrective Action: The Retaliation Form was updated and found to be compliant with the standard and perceived to be helpful in prompting the user to check for retaliation in all the ways required in the sub-sections of this standard. Retaliation Monitoring was a standing agenda item for the PREA Readiness Team and was discussed regarding retaliation against a youth who had reported a grievance/incident. The audit team received documentation of retaliation monitoring for all applicable investigations.

Analysis: Written policies are consistent with this standard. Also, forms and documentation reviewed, and interviews conducted, show compliance with this standard.

Finding: The facility has shown full compliance with this standard.

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

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Policy Room Confinement/Personal Time-Out and Alert Policy & Proc.#: 3.19 Effective Date: November 25, 2013; and, Security and Control: Juvenile Discipline Policy & Proc.#: 3.10 Effective Date: November 1, 2010 contain these standards. The PAQ states there have been no instances of residents who allege to have suffered sexual abuse being placed in isolation in the past 12 months. Interviews with staff and residents bear this out, since they express no knowledge of anyone being involuntarily isolated for their own protection. Also, residents who have been in trouble unrelated to sexual abuse indicate that residents always get their rights when briefly separated from others.

Analysis: The combination of policy that is clear on these issues, and documentation of practice, along with interviews with staff and residents who are witnesses to what happens with reports are made, and when incidents happen when residents need protection, all indicate compliance with this standard.

Finding: The facility has demonstrated compliance with this standard.

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 entity 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

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Although criminal investigations are conducted by law enforcement, BCYSC has policy and procedure related to agency investigations. The agency does not terminate an investigation solely because the source of the allegation recants the allegation. Substantiated allegations of conduct that appear to be criminal are referred for prosecution. The agency retains all written reports pertaining to the administrative or criminal investigations of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. The credibility of an alleged victim, suspect, or witness will be assessed on an individual basis, and it will not be determined by the person's status as resident or staff. No polygraphs are required. Investigations include an effort to determine whether staff actions or failures to act contributed to the abuse. Such investigations will be documented in written reports, which will include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. The departure of the alleged abuser or victim from the employment or control of the facility or agency will not provide a basis for terminating an investigation. When outside agencies investigate sexual abuse, the facility will cooperate with outside investigators and will endeavor to remain informed about the progress of the investigation. At the time of the Interim Report, however, the agency had not provided documentation that demonstrated completion of adequate investigative work in practice, as required by this standard.

Corrective Action: Updated investigations and related policies and procedures were provided to the audit team, all of which were compliant with the standard.

Analysis: By the end of the CAP, policy was accompanied by documented proof of practice, showing investigations completed on all allegations and suspicions of sexual abuse and/or sexual harassment.

Finding: The agency has shown compliance with this standard.

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

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BCYSC PREA Policy and Procedure #:3.18 requires the agency to "Impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated." Investigative work reviewed by the audit team, as well as interviews with investigators, indicate an understanding of this standard.

Analysis: Policy, training, and practice seem to speak in one accord in this matter, as confirmed by interviews conducted.

Finding: The agency has shown compliance with this standard.

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 an agency 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.

BCYSC PREA Policy 3.18 does provide for all sub-sections of this standard. It requires that any resident who makes an allegation that he or she suffered sexual abuse in the facility is notified as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation, and that the notification is documented. Following a resident's allegation that a staff member has committed sexual abuse against the resident, the facility subsequently informs the resident (unless the agency/facility has determined that the allegation is unfounded), whenever the staff member is no longer posted within the resident's unit; the staff member is no longer employed at the facility; the agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or the agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. Following a resident's allegation that he has been sexually abused by another resident, they will inform the alleged victim when they learn that the alleged abuser has been indicted on a charge related to sexual abuse within the facility, or if they learn that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. However, at the time of the Interim Report, investigative materials reviewed did not indicate that the residents were receiving information, applicable to this standard, that is based on a full review (or investigation) of the circumstances surrounding the incident. It appeared that some are asked to sign a "Major Incident", while some are told something verbally, while others may not be told anything regarding a finding.

Corrective Action: The agency developed new notification letter templates, providing removable verbiage, which assist the administrator notifying the resident to follow all sub-sections of this standard, and in documenting the notifications. This template has been reviewed by the PREA Team, approved, distributed, and implemented for use.

Analysis: A review of all investigations indicates all notifications have been done as per the minimum requirements of this standard, but few residents have been notified, since the applicable residents are no longer at the facility and the agency's obligation terminates once the resident is released. A policy review and interviews with the investigator and other administrators indicate an understanding of this requirement.

Finding: The facility is in compliance with this standard.

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

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PREA Policy Section K states: "Discipline of Employees: Violation of this policy is cause for discipline up to and including termination. The Director or Designee will take any action necessary to enforce this policy. Any staff member or non-juvenile who violates this policy may be prohibited from contact with juveniles. All terminations for violations of agency sexual misconduct policies, or resignations by staff that would have been terminated if not for their resignation, will be reported to law enforcement and any licensing bodies responsible for licenses that are required for the employee's position. Acts of sexual abuse will not be tolerated. Employees will be disciplined, which may include termination of employment." Sections L goes on, "Corrective Action for Contractors and Volunteers: Any contractor or volunteer who engages in sexual abuse will be prohibited from contact with juveniles and shall be reported to law enforcement agencies, unless the activity was proven as clearly not criminal by law enforcement, and to relevant licensing bodies. The facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with juveniles, in the case of any other violation of agency sexual misconduct policies by a contractor or volunteer." Although no staff or volunteers have been found to have violated sexual harassment or sexual abuse policies, the Director, the PREA Coordinator, and all other administrators interviewed are adamant that these policies will be followed without hesitation.

Analysis: The facility has demonstrated that the policies are clear regarding this standard, as well as the related training. Administrators are aware of the policies and attest that these are in practice.

Finding: The facility has shown compliance with this standard.

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

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Since some potential for confusion was identified during the pre-audit and on-site audit work, the agency worked to address these. The PREA Compliance Officer sent the auditor the following explanation regarding changes made: "Volunteer Contractor PREA Notifications form has been updated to reflect that Youth Services Center strictly prohibits any sexual contact between staff, contractors, volunteers and residents, and expects staff, contractors, and volunteers to keep professional boundaries in all of their interactions with residents. Additional updates also reflect that Sexual contact between staff, contractors, volunteers and a resident is deemed to be non-consensual under all circumstances. Consent is not an affirmative defense to sexual contact between staff contractors, volunteers and resident, due to the custodial status of residents, and the unequal nature of the relationship. Consenting sexual contact between residents is against facility rules and shall be reported to a YSC Management Official. Attached PREA Notification Form to this e-mail response is evidence of compliance with the standard. Contractors and volunteers on site have been trained on the changes. Any future volunteer or contractor who enters the facility will be retrained upon their arrival. Evidenced of compliance with the attached document titled Volunteer Contractor Notification Acknowledgment Sept. 2018. Pdf with recently dated volunteer/contractor PREA Notification forms indicating that those individuals on site have been trained on the changes and their signature acknowledgment." These were the only concerns raised regarding this standard. Policy reviews and interviews conducted all indicated compliance with this standard in practice.

Analysis: Changes made to clarify policies and avoid confusion add strength to the compliance already established by the facility. Administrators who supervise volunteers, and other staff, verify the volunteer program complies with PREA in practice.

Finding: The facility has shown compliance with this standard without corrective action.

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)

- 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

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During the pre-audit process, some inconsistencies were identified that might cause non-coercive sexual activity to be considered to be abuse. This was resolved by policy updates and corrections on other materials. PREA Compliance Manager Jason Elis provided updated policy with the following explanation: "Policy 3.10 Security and Control Juvenile Discipline has been updated to reflect changes in the matrix penalties for inappropriate behavior of a sexual nature and a separate rule violation for consensual sexual acts between residents and those updates are evidenced on policy and procedure 3.10 page 9. Matrix is the tool to utilize when providing disciplinary sanctions updates have been provided to all disciplinary hearing officers. Consensual sex between residents has been identified as a rule violation in the training of staff and updated in the 3.20 Sexual Misconduct policy." Mr. Elis also provided training and verification that employees have received the policy updates. No residents have been disciplined for sexual abuse or harassment in the past 12 months, according to documentation reviewed and interviews conducted.

Analysis: Policies have been updated and implemented into practice. Those interviewed verify an understanding of the policies and can give examples of residents being given consequences for rule violations that have not been determined to be sexual abuse or sexual harassment.

Finding: The facility has shown compliance with this standard.

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

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PREA Policy & Proc.#: 3.18 Effective Date: August 13, 2013 and Juvenile Services: Social Services Policy & Proc.#:6.2 Effective Date: January 22, 2013 comply with this standard. Residents and staff indicate that the Social Services/Behavioral Health Department provides appropriate care, and conducts follow-up care and screenings, and is available as needed. Interviews and documentation provided support these claims. In addition to screening and mental health tools used to diagnose and treat residents, documentation provided includes training materials for mental health professionals, and resources regarding male victims of rape, overcoming past painful experiences, and lesbians and sexual assault. The only issue brought up during the audit was when the behavioral health staff were accused of not sharing information the other departments needed to work with the youth. This was addressed during the 30 days after the on-site audit.

Analysis: Policy, training materials, screenings conducted, documentation of follow-up care, and information gathered from interviews, provided the audit team with verification of compliance with this standard.

Finding: The facility has shown compliance with this standard.

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.

Interviews and reviews of policy indicate that resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. Medical and mental health staff maintain secondary materials documenting the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff, in the event that health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning contraception and sexually transmitted infection prophylaxis. Treatment services are provided to every victim, without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. There were three examples of this care being provided (although the abuse did not occur at BCYSC). The documentation was reviewed by the auditor. Also, the audit team verified with local providers that care is available.

Analysis: The facility has policies in place that are consistent with this standard, and it has shown that they follow the policies. Providers in the community also verify that these services are in place for residents of BCYSC. Interviews with staff (including medical and mental health staff), and interviews with residents, also indicated full compliance with this standard.

Finding: The facility has shown compliance with this standard.

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.) ☒ 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.) ☒ 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.

BCYSC offers medical and mental health evaluation and, as appropriate, and treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. Resident victims of sexual abuse are offered tests for sexually transmitted infections as medically appropriate. Treatment services are provided to the victim without financial cost, and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Interviews indicate that the evaluation and treatment of victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. The facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history, and it offers treatment when deemed appropriate by mental health practitioners.

Analysis: The facility has policies in place that are consistent with this standard, and it has shown documentation that they follow the policies. Providers in the community also verify that these services are in place for residents of BCYSC.

Finding: The facility shows compliance with this standard.

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.

The facility was compliant with this standard at the time of the Interim Report, because, even when investigations were not completed, Incident Reviews were completed.

Analysis: PREA Policy & Procedure #: 3.18 requires incident reviews, as required in this PREA standard. Investigative materials indicate that these have been completed. Recommendations for improvement made during Incident Reviews are being implemented at the facility.

Finding: The facility has shown compliance with this standard.

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.

Although the facility had been keeping logs, documenting responses, and performing Incident Reviews, a problem at the time of the Interim Report was that the agency had not been keeping track of sexual misconduct in a way that differentiated among sexual harassment, sexual abuse, and rule violations. A number of alleged rule violations, such as teens making vulgar noises or talking about sexual activities, were included in a broad "PREA" category.

Corrective Action: During the CAP, the agency developed, tested, and implemented a new sexual abuse and sexual harassment data log and tracking system. They wrote their 2018 Annual Report.

Analysis: BCYSC, by the end of the CAP, demonstrated that it collects accurate, uniform data for every allegation of sexual abuse, using a standardized instrument and set of definitions, and that it writes an annual report. The agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

Finding: The agency has shown compliance with this standard.

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.

BCYSC PREA Policy is consistent with the standard, stating that, "The Director or Designee will maintain a tracking system that records all allegations of sexual misconduct and their disposition. The Director or Designee will maintain, review, and collect data as needed from all available incident-based

documents, including reports, investigation files and sexual abuse incident reviews. The incident-based data collected will be aggregated at least annually and will include, at a minimum, the data necessary to answer all questions from the most recent survey of the Survey of Sexual Violence conducted by the Department of Justice". The problem at the time of the Interim Report was that the agency had not been keeping track of sexual misconduct in a way that differentiated among sexual harassment, sexual abuse, and rule violations. A number of alleged rule violations, such as teens making vulgar noises, or randomly referencing sexual activities, or body parts, were included in a broad "PREA" category, yet no investigations had been conducted, according to the PAQ. Putting all sexual harassment and sexual abuse under the same umbrella as all sexual misconduct and rule violations, then not conducting full investigations, made it impossible to gather and review the data for corrective action as required by the standard.

Corrective Action: During the CAP, the PREA Review Team continued to meet, under the direction and facilitation of the PREA Coordinator. The team reviewed the findings from the investigation of every allegation of sexual abuse and harassment. The allegations were sorted out and logged according to the Standard, and in a way that collected the information needed for the Survey of Sexual Victimization. This information was provided to the audit team, along with documentation of corrective actions.

Analysis: At the end of the CAP, the agency has shown policy and practice consistent with the standard. They have verified this through an expanded and improved system of logging and tracking complaints, through data collection, and through corrective actions.

Finding: The agency has shown compliance with this 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.

BCYSC ensures that incident-based and aggregate data are securely retained. Agency policy requires that aggregated sexual abuse data from facilities under its direct control, and from private facilities with which it contracts, to be made readily available to the public, at least annually, through its website. Before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers. The agency maintains sexual abuse data collected pursuant to ß115.387 for at least 10 years after the date of initial collection, unless Federal, State or local law requires otherwise. For the 2017 Annual Report: https://www.bernco.gov/uploads/FileLinks/70579728cbb94500a91822c461b3e3d4/PREA_final_annual_report_FY2017.pdf

Analysis: The agency has shown policy, documentation, and practice to verify compliance with this standard. Although the agency was compliant with this standard at the time of the Interim Report, improvements were made on the data logging and collection system during the time of the Correction Action Plan. According to the PREA Coordinator, these improvements will be reflected in published reports.

Finding: The agency has shown compliance with this standard.

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 three-year period starting on August 20, 2013, and during each three-year period thereafter, 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? (N/A before August 20, 2016.) ☒ Yes ☐ No ☐ NA

115.401 (b)

- During each one-year period starting on August 20, 2013, 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? ☒ Yes ☐ No

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 inmates, residents, and detainees? ☒ 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.

BCYSC was audited in April 2015.

Analysis and Finding: The agency has shown policy, documentation, and practice to verify compliance with this standard. The agency has shown compliance with this standard

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 within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. 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 previous audit can be viewed at:
https://www.bernco.gov/uploads/FileLinks/70579728cbb94500a91822c461b3e3d4/2015.PREA_Bernalillo_JSC_Audit_report.pdf

Analysis and Finding: The agency has shown policy, documentation, and practice to verify compliance with this standard. The agency has shown compliance with this standard.

AUDITOR CERTIFICATION

I certify that:

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

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

☒ I have not included in the final report any personally identifiable information (PII) about any 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.

D. Will Weir 04-05-2019

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.