PREA AUDIT REPORT ☐ INTERIM ☒ FINAL
JUVENILE FACILITIES

Date of Report: July 7, 2017

Auditor Information			
Auditor name: Glen E. McKenzie, Jr., M.S.H.P.			
Address: 202 Walton Way, Suite 192-141, Cedar Park, Texas 78613			
Email: GlenEMcKenzieJr.LLC@austin.rr.com for PREA Audit Purposes Only			
Telephone number: 512-576-1800			
Date of facility visit: July 11-12, 2017			
Facility Information			
Facility name: Fort Bend County Detention Center - Pre/Post Adjudication			
Facility physical address: 122 Golfview Drive, Richmond, Texas 77469			
Facility mailing address: (if different from above)			
Facility telephone number: 281-633-7400			
The facility is:	☐ Federal	☐ State	☒ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☒ Correctional	☒ Detention	☒ Other
Name of facility's Chief Executive Officer: Matthew "Kyle" Dobbs			
Number of staff assigned to the facility in the last 12 months: 17			
Designed facility capacity: 80			
Current population of facility: 48			
Facility security levels/resident custody levels: secure pre-adjudication detention and secure post-adjudication			
Age range of the population: 10-17			
Name of PREA Compliance Manager: N/A		**Title:**	
Email address:		**Telephone number:**	
Agency Information			
Name of Facility: Fort Bend County Detention Center - Pre/Post Adjudication			
Governing authority or parent facility: (if applicable) Fort Bend County Juvenile Probation Department			
Physical address: 122 Golfview Drive, Richmond, Texas 77469			
Mailing address: (if different from above)			
Telephone number: 281-633-7400			
Facility Chief Executive Officer			
Name: Matthew "Kyle" Dobbs		**Title:** Chief Juvenile Probation Officer	
Email address: kyle.dobbs@fortbendcountytx.gov		**Telephone number:** 281-633-7400	
Facility-Wide PREA Coordinator			
Name: Chance Bagley		**Title:** PREA Coordinator	
Email address: chance.bagley@fortbendcountytx.gov		**Telephone number:** 281-633-7352	

AUDITFINDINGS

NARRATIVE

Overview

The Prison Rape Elimination Act (PREA) on-site audit of the Fort Bend County Juvenile Detention Center in Richmond, Texas was conducted on July 6-7, 2017 by Glen E. McKenzie, Jr., M.S.H.P. from Cedar Park, Texas, and a U.S. Department of Justice Certified PREA Auditor for Adult and Juvenile facilities. On the first day of the audit, the Auditor conducted an entrance conference, toured all areas of the facility and began interviews of random and specialized staff and random residents. On the second day of the audit, the Auditor spent the balance of the on-site audit interviewing additional specialized staff, random and specialized residents, completed all interviews, reviewed selected staff and resident files and additional documents. Following completion of the on-site visit on July 7, 2017, the Auditor conducted an exit conference with the facility administration and staff to discuss preliminary findings and the subsequent audit processes and timeframes. The Auditor's comments were positively received during the audit by all the facility staff and administrators. Residents and staff were readily accessible at all times to the Auditor for the conduct of formal interviews. The facility administrators provided unimpeded access to all parts of the facility to the Auditor at all times and provided ample office space during the on-site audit. The Chief Probation Officer and facility staff demonstrated that PREA compliance is a priority as demonstrated by the quality of preparation of the Pre-Audit Questionnaire (PAQ) and organization of information provided to the Auditor.

Pre-Audit Phase

On June 2, 2017, the Auditor sent the facility the PREA Audit Notices to be posted in the facility. On June 2, 2017, the Auditor received electronic photographic evidence which was dated to demonstrate that proper posting of these notices had been placed in the resident housing units, the main entrance of the facility, other areas of the facility and in the administration area of the facility. The audit notice had also been posted on the facility's website as verified by the Auditor. As of the audit report date, the Auditor had not received any confidential correspondence via postal service mail or during the on-site audit.

The PREA Coordinator was requested to complete the Pre-Audit Questionnaire (PAQ) by June 21, 2017. The facility provided the completed PAQ to the Auditor along with supporting documents electronically on June 29, 2017 preceding the on-site review portion of the audit. Pre-audit preparation by the Auditor included a thorough review of all documentation and materials submitted by the facility along with the data included in the completed Pre-Audit Questionnaire. The documentation reviewed included facility policies, procedures, forms, education materials, training curriculum, organizational charts, posters, brochures and other PREA related materials that were provided to demonstrate compliance with the PREA standards. This review prompted few questions which were answered by the PREA Compliance Coordinator on July 5, 2017 on the afternoon of July 5, 2017 in a meeting with the facility PREA Compliance Coordinator.

On June 2, 2017, the Auditor requested the facility to compile a listing of key administrative personnel, specialized staff (e.g., contract administrator, human resources staff, medical and mental health staff, screening staff, intake staff, investigative staff, volunteers, contractors, etc.) and specialized residents (e.g., residents reporting abuse, disabled residents, LGTBI residents, etc.). The listings were provided to the Auditor on the afternoon of July 5, 2017 from which he selected the staff and residents (i.e., administration, specialized and random staff and specialized and residents still in the facility, etc.) to be interviewed. The Auditor also selected specific files (e.g., new hires, employees promoted, employees disciplined, residents disciplined, investigations, training records, etc.) to be reviewed during the on-site audit. On the first day of the audit, the facility provided the Auditor with an updated listing of all residents in all housing units from which the Auditor made the final selection of random residents to be interviewed that represented all housing units.

On-Site Audit Phase

The evening prior to the audit, the Auditor meet with the Executive Director/Chief Juvenile Probation Officer, Assistant Agency Director, The Detention Center Director and the PREA Coordinator for reintroductions and general discussions. On the morning of July-6, 2017 the Auditor arrived at the facility at 8:15 a.m. and was shown to a conference room in the detention center visitors' wing of the building which would function as working base during the audit. The Auditor began by conducting an entrance conference with agency and facility administration at 8:30 a.m. After introductions and welcoming remarks were made by the Executive Director/Agency Chief Juvenile Probation Officer and Assistant Agency Director, the Auditor discussed the audit schedule and an overview of the audit processes. Following the entrance conference, the Auditor was escorted into detention facility for purposes of conducting an on-sight tour of the facility. During the tour the Auditor observed camera placements to identify potential blind spots, observed staff placement and resident supervision, observed zero tolerance posters, PREA audit notice postings, reviewed the video monitoring system in the control room area, confidential resident files, unit logs, grievance forms, locked grievance boxes and hotline phone numbers posted in each living unit. The Auditor was provided unimpeded access to all parts of the facility, all secure rooms and storage areas in the facility. During the tour the Auditor informally interviewed staffs and residents regarding sexual safety and facility policies and procedures. During the tour, any additional questions were answered by executive and upper-level management staff. During the remaining duration of the on-site audit, the Auditor conducted staff and resident interviews in the private visitation room within the detention center. Educational services were currently not provided as the audit occurred during their summer break. Educational services are provided contractually through the Lamar Consolidated Independent School District.

Site Review

On the first day of the audit after the entrance conference, the Auditor toured the physical plant escorted by Mr. Chance Bagley, PREA Coordinator, the Executive Director/Agency Chief Juvenile Probation Officer, Assistant Agency Director and Detention Center Director. The Auditor spoke with numerous staff and residents informally during the tour which covered all housing and common areas of the facility, day areas, programming areas, medical office, resident records area, visitation areas for families, private visitation areas for attorney/privileged individuals, kitchen, mechanical room, gymnasium, indoor recreation area, intake screening area reception holding area and showers and toilet areas. The Auditor noted video cameras strategically placement inside and outside throughout the facility and reviewed the video monitoring setup in the control room areas. The Auditor observed Notices of the PREA Audit posted throughout the facility as required.

During the on-site review of the physical plant, the Auditor observed, among other things, the facility configuration, staff supervision of residents, resident behaviors, dorm layouts including individual wet sleeping rooms, shower/toilet areas, resident telephones, placement of PREA posters and PREA informational resources, security monitoring, resident movement procedures, resident programming and resident interaction with staff. Residents spoke highly of facility staff and appeared to interact appropriately and respectfully.

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

Detention Center

- Unit A Male (18 rooms); (14 residents)
- Unit B Female (12 rooms); (10 residents)
- Unit C Male (18 rooms); (18 residents)
- Dorm 1 Male vacant (8 beds); (0 residents)
- Dorm 2 vacant (8 beds); (0 residents)
- Leadership Academy MALE (8 beds); (6 residents)
- Holding Male (8 rooms); (0 residents)

Interviews

Formal private interviews were conducted with facility staff and residents. Eighteen total facility administrator/staff members were interviewed during the on-site review which included administrative staff, random staff and specialized staff. Seven (7) staff members performed multiple functions thereby reducing the overall number of specialized staff individual interviews. The auditor interviewed ten (10) random staff, seven (7) staff that performed 10 specialized staff functions. Interviews included random staff representing Shift 1, Shift 2 and the Recreation Director (10:30 A.M. – 6:30 P.M. in the programs. There were no third shift random staffs available for interview.

The facility shifts are:

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

During the on-site audit, the auditor interviewed the following: Executive Director/Chief Juvenile Probation Officer, Assistant Chief Probation Officer, Detention Center Director, PREA Compliance Coordinator, (all who are intermediate/higher-level facility staff who conduct unannounced visits to the facility during the all shifts), medical staff, human resources staff (PREA Coordinator), incident review team staff, staff members who monitor for retaliation, staff who performs screening for risk of victimization and abusiveness, intake staff, security staff and ten (10) random correctional officers who all are first responders. There was no volunteers or contractors interviewed as none were at the facility or available during the audit. All staff was interviewed using the DOJ protocols that question their PREA training and overall knowledge of the facility's zero tolerance policy, reporting mechanisms available to residents and staff, the response protocols when a resident alleges abuse, first responder duties, data collection processes and other pertinent PREA requirements. The Auditor noted that all staffs were particularly knowledgeable of their responsibilities in the provision of prevention, detection and response to sexual abuse and sexual harassment and had a commitment to helping residents become responsible, caring citizens.

There were no volunteers or contractors available for interview during the audit.

The resident population ranged from 52 residents on August 1, 2016 to 46 residents on June 20, 2017. According to the PAQ, in the previous 12 months, a total of 728 residents had been admitted to the facility. The age range of resident population is 10 years to 17 years of age. No resident had requested to speak with the auditor nor had the auditor received any written correspondence from any resident or staff. In the prior 12 months, there had been zero (0) allegations of sexual abuse and there had been zero (0) allegations the facility received that a resident was abused while confined at another facility.

On the first day of the on-site review, there were 48 residents (38 males and 10 females) housed in the facility in four housing units. Due to resident populate, three (3) resident housing units were unoccupied. The Auditor interviewed 10 (ten) residents combined from all four housing units representing approximately 21% of the resident population. All ten (10) resident interviews were residents randomly selected. Both male and female residents were interviewed; seven (7) males, three (3) females. There were no residents who reported a sexual abuse, no residents who were disabled and limited English proficient, and no residents who identified as transgender, intersex, gay, lesbian or bisexual. There were no residents who had disclosed prior sexual victimization during risk screening and there were no residents placed in isolation for the purposes of separating residents who identified as transgender, intersex, gay, lesbian or bisexual**.** Residents were interviewed using the Department of Justice (DOJ) protocols that question their knowledge of a variety of PREA protections generally and specifically their knowledge of reporting mechanisms available to residents to report sexual abuse or harassment. All residents said they would be comfortable with reporting any incident of sexual abuse or sexual harassment to any staff, supervisor or counselor at the facility.

The Auditor reviewed the Memorandum of Understanding (MOU) between the facility and Harris Health System

to provide SANE and SAFE services and the agreement between the Fort Bend County Juvenile Board and the Fort Bend County Women's Center to provide a 24- hour hotline for reporting sexual abuse and sexual harassment as well as counseling services for victims and victim support. The contract is valid through May 11, 2019. The auditor left a telephone message with the Administrative Director, Risk Management and Patient Safety Department, Harris Health System to confirm the MOU which provides SANE/SAFE services to be provided at no cost to the resident as required. The Auditor further reviewed an email communication from the Administrative Director confirming the Harris Health System would provide medical-forensic examinations to the facility upon request. The Auditor spoke with the Executive Director of the Fort Bend Women's Center who confirmed the written agreement with the facility to provide victim advocacy and counseling services if that is needed. The Executive Director of the Fort Bend Women's Center stated that services had not been necessary as of this date.

All allegations of sexual abuse or sexual harassment are to be reported to the Fort Bend County Sheriff's Office which had agreed through a Memorandum of Understanding to conduct criminal investigations. The auditor communicated electronically with the Fort Bend County Sheriff's Office Criminal Investigations Division Sergeant, Crimes Against Children and Elderly who confirmed that criminal investigative services would be provided to the detention center as needed. The Chief Probation Officer and the Sheriff's Office representative confirmed the accuracy with statements contained in the PAQ that there had been zero (0) criminal investigations of allegations of sexual abuse. Administrative investigations are to be conducted by two (2) trained staff at the facility. The auditor also contacted the toll free hot-line (TJJD) and spoke with an operator who explained their office accepted sexual abuse allegations at any time.

The Fort Bend County Juvenile Detention Center's mission is stated as "Our mission is to rehabilitate delinquent children. The Fort Bend County Juvenile Probation Department has adopted the attitude of "whatever it takes". We, as an agency, are serious about turning young lives around and strive to do so in every department division and at every position level. Professionalism, creative program development and implementation, juvenile and family accountability, all come together in a synergistic manner to give our clients the best possible opportunity to make a lasting positive change in their lives."

File Review

The Auditor requested the facility to provide a listing of personnel and resident files for possible review. From those listings, the Auditor selected a random sample of files to review and notified the facility. All files were provided to the Auditor in the main conference room where the Auditor was based. Prior to the on-site audit, the PREA Coordinator provided the Auditor with a listing of facility staff by hire/promotion dates beginning in August 2016 which cited dates for criminal records and sexual abuse checks and documentation of check with prior institutional employers. In order to verify compliance, the Auditor selected at random three (3) of the 17 files for new employees which were reviewed and determined them compliant with the PREA standards applicable to new hires. The Auditor reviewed three (3) of the four (4) personnel files for individuals who had recently received promotions and determined those files to be compliant with the PREA standards. The Auditor reviewed a "Volunteer/Contractor Proof of PREA Requirements Training" spreadsheet identifying 78 individuals and determined that all volunteers and contractors training requirements had been met. Prior to the on-site audit, the PREA Coordinator also provided the Auditor with a listing of residents admission since November 2016 citing the date of admission and the provision of each individual orientation, screening date and comprehensive education dates. The Auditor selected case files for three (3) of the current 48 youth in the facility and reviewed each file reviewed to evaluate screening and intake procedures, resident education and other general programmatic areas. The resident files reviewed were determined them compliant with PREA standards applicable to resident admission, screening and educational procedures.

Exit Conference

The Auditor conducted a general exit conference with the Executive Director/Chief Juvenile Probation Officer and the Assistant Chief Juvenile Probation Officer on late afternoon of Thursday, July 6, 2017 prior to completing staff

interviews. The administrators were very open and receptive to discussion of any area where PREA compliance might possibly be improved. Following that discussion, the Auditor continued the staff interviews prior to exiting the facility. Following the completion of interviews, the Auditor discussed general observations/conclusions and the audit report preparation procedures with the PREA Coordinator prior to exiting the facility. On the morning of Friday, July 7, 2017, the PREA Coordinator provided the remaining documentation which had been requested by the Auditor.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Fort Bend County Juvenile Detention Center is located in the Richmond, Texas. Richmond is a city in Fort Bend County, Texas, United States. As of the 2010 census, the city had a population of 76,201. It is the county seat of Fort Bend County. Fort Bend County has a population of approximately 740,000 residents.

The Fort Bend County Juvenile Detention Center operates the pre-adjudication and post-Adjudication, secure detention center. The facility is located at the Fort Bend County Juvenile Service Department headquarters at 122 Golfview Drive, Richmond Texas 77469, adjacent to the Fort Bend County Sheriff's Department. The detention center is a secure environment for youth charged with an offense and pending a court hearing. It is designed to provide a safe living environment and a full range of services for the juvenile to include: medical, educational, nutritional, psychological and recreational services.

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

The detention center is an 80 bed facility consisting of both individual rooms and dormitories. There are three dormitories holding eight (8) juveniles each, with one dorm reserved for the Juvenile Leadership Academy. Juveniles who have been in detention for at least two (2) weeks and who have demonstrated exemplary behavior may be placed in these dormitories. The detention center offers a full range of services including educational, medical and psychological services along with recreational and spiritual programs.
The detention center provides three (3) single cell occupancy housing units. Of these three (3) units, one (1) is designated for females and two (2) units are designated for male residents ages 10-15 in a unit and 15-17 year old residents. Educational services are provided contractually through the Lamar Consolidated Independent School District.
The center is equipped with academic classrooms, a medical offices, laundry, kitchen, dining room, gym, indoor recreational area, visitation area, control center, and administrative offices. The grounds contain an indoor recreation room and an outdoor covered gymnasium/basketball court, and a baseball field.

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

The Fort Bend County Juvenile Detention Center has 48 video cameras in use inside the facility as well as on the exterior of the facility of which all cameras were currently operational. The video cameras with sound are placed in corridors, housing units, program areas and exterior recreational areas. There is one (1) visitation rooms in which the video camera has no sound in order to provide a secure area for confidential visits. There are no cameras in individual resident rooms or in the shower or toilet areas. The Education building is equipped with video cameras covering the hallways and a camera in each classroom. All cameras are continuously monitored by staff in the secure control room.

The facility is very well maintained, in good repair and is exceptionally clean. Housing units are well equipped and provide residents with a comfortable environment. Dorms and individual resident rooms are painted colors to enhance the housing units and reduce the institutional feel. In walking through all the

housing units in the facility as well as the educational areas, the Auditor noted that the facility was quiet and order was well maintained in all areas. Staffs appear to have good relationships with the residents and residents appear to follow the direction of staff which contributes to a calm environment conducive to rehabilitation.

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

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

The detention facility offers a variety of programming and services for residents. There is a nurse on site 16 hours per day and a nurse in available to examine the juveniles upon request 24 hours a day. Upon advice and recommendation from the facility nurse or in an emergency the juvenile will be transported by detention staff to Harris Health System Richmond, Texas. In the case of a major medical need such as surgery, the child's parents, guardian or custodian may be responsible for medical expenses. Medical Services for detained youth are provided through a contract basis with a licensed physician who comes to the facility on a regular basis or upon request. The facility has a strong community volunteer program consisting of 82 volunteers who serve the facility residents.

SUMMARY OF AUDIT FINDINGS

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

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

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

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

All facility staff interviewed stated they had received detailed training in PREA policies and procedures and could

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

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

PREA Standards Compliance Overview – Final Audit Report

Fort Bend County Juvenile Justice Center has achieved compliance with all PREA standards as of the date of this final report. The summary of compliance based upon this final report is found below.

PREA Standards Compliance Overview – Final Audit Report

Number of standards exceeded: 0

Number of standards met: 39

- **§115.311; §115.312; §115.313; §115.315; §115.316; §115.317**
- **§115.321; §115.322;**
- **§115.331; §115.332; §115.333; §115.334; §115.335;**
- **§115.341; §115.342**
- **§115.351; §115.352; §115.353; §115.354;**
- **§115.361; §115.362; §115.363; §115.364; §115.365; §115,367; §115.368;**
- **§115.371; §115.372; §115.373; §115.376; §115.377; §115.378; and**
- **§115.381; §115.382; §115,383; §115.386; §115,387; §115.388; §115.389.**

Number of standards not met: 0

Number of standards not applicable: 2

- **§115.318; and**

- **§115.366.**

Total Standards: 41

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. Agency Policy 17.1 Prevention Planning [I] Zero Tolerance
2. Agency Policy 17.1 Prevention Planning [II] Contracting With Other Entities For the Confinement of Residents
3. Website denoting PREA Coordinator: http://www.fortbendcountytx.gov/modules/showdocument.aspx?documentid=37447

Findings (By Subsection):

Subsection (a): Agency Policy 17.1 (I) Zero Tolerance provides for a comprehensive policy on sexual abuse and sexual harassment. The policy clearly mandates zero tolerance toward all forms of sexual abuse and sexual harassment. The policy contains definitions that are compliant and consistent with the PREA definitions in the PREA Definitions section. The policy further outlines the facility's approach to preventing, detecting, and responding to sexual abuse and sexual harassment.

Subsection (b): Chance Bagley is the designated facility wide PREA Coordinator and his official title is PREA Coordinator/Supervisor Training/Compliance staff person. He reports directly to the facility Executive Director/Chief Juvenile Probation Officer. His contact information is found on the Fort Bend County web site: http://www.fortbendcountytx.gov/modules/showdocument.aspx?documentid=37447. The PREA Coordinator reports that he has sufficient time and authority to develop, implement and oversee facility efforts to comply with PREA.

Subsection (c): This is a single-facility agency and this subsection is N/A.

Corrective Action: None.

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. Agency Policy 17.1 Prevention Planning [II] Contracting With Other Entities For the Confinement of Residents
2. Agency contracts with service agencies (Clause 1) requiring compliance with the Prison Rape Elimination Act of 2003.
3. Interviews with the following:
   a. PREA Coordinator
   b. Facility's Contract Administrator

Findings (By Subsection):

Subsection (a): Fort Bend County Juvenile Detention Center policy 17.1 (II) Contracting With Other Entities For the Confinement of Residents provides all residential service contracts must include provisions that require the service provider to comply with PREA. The facility currently has no residential service provider contracts. All future residential service contracts are required by agency policy to contain the PREA language that requires compliance of the service provider with the PREA standards.

Subsection (b): Fort Bend County Juvenile Detention Center policy 17.1 (II) Contracting With Other Entities For the Confinement of Residents requires that residential contracts will provide that the facility will monitor the progress of their residential service providers at regular intervals. Interviews with the Executive Director/Chief Juvenile Probation Officer and the Assistant Chief Juvenile Probation Officer confirmed this requirement will be performed if residential contracts are needed in the future.

Corrective Action: None.

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

☐ Not Applicable

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

Evidence Reviewed (documents, interviews, site review):

1. Agency policy 17.1 Prevention and Planning[III] Supervision and Monitoring
2. Number and placement of video cameras inside and outside the facility

3. Safe Housing Staffing Plan Assessment and Annual Review [May 1, 2017]
4. FBC Juvenile Detention Center Shift Log
5. Interviews with the following:
   a. Detention Center Director
   b. PREA Coordinator
   c. Intermediate or Higher-Level Facility Staff

Findings (By Subsection):

Subsection (a): Policy 17.1 Supervision and Monitoring [III-5] requires the facility to develop staffing plans for its facility. The plans demonstrate the calculation of the staffing patterns required.

Subsection (b): Policy 17.1 Supervision and Monitoring [III-2] dictates that deviations are only allowed during limited and discrete exigent circumstances. There had been no deviations from the staffing plan documented on the PAQ. The agency has developed a form to document such deviations should that be necessary.

Subsection (c): This subsection regarding the new juvenile staffing ratios is not applicable until October 1, 2017. The facility exceeds this subsection. The FBC Juvenile Detention Center Shift Log was used to demonstrate that the facility has maintained a minimum of 1:8 ratio during resident waking hours and a 1:16 ratio during resident sleeping hours. Interviews with the Detention Center Director and the PREA Coordinator confirmed that the required ratios have been met.

Subsection (d): The staffing plan reviewed on May 1, 2017 had previously reviewed within the past 12 months as required. In discussions with the PREA Coordinator, he indicated the facility plans to perform a subsequent annual review of the staffing plan prior to October 1, 2017 confirm and to document the PREA mandated staffing ratio.

Subsection (e): Policy 17.1 Supervision and Monitoring [III-5] requires intermediate and higher level supervisory personnel in each program to conduct and document unannounced rounds at least once per shift each month. The facility exceeds this subsection as documented that not only intermediate-level or higher level supervisors conduct and document unannounced rounds, the Auditor noted that regularly, the Executive Director/Chief Juvenile Probation Officer, Assistant Chief Juvenile Probation Officer and the Detention Center Director themselves conduct unannounced rounds. Documentation of the unannounced visits by intermediate and higher-level supervisors is documented on the "PREA Unannounced Round Form". The PREA Unannounced Round Form is submitted to the PREA Compliance Coordinator and other higher level Facility management for review. A random review PREA Unannounced Round Forms documented unannounced visits on all shifts monthly as required.

Corrective Action: None

Standard 115.315 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. Agency policy 17.1 Prevention and Planning [IV] Limits to cross-gender viewing and searches
2. Interviews with the following:
    a. random residents
    b. random staff

Findings (By Subsection):

Subsection (a): Facility policy 17.1 Limits to cross-gender viewing and searches [IV-1 (D)] prohibits cross-gender strip or pat searches, only in exigent circumstances or when performed by medical practitioners; allowing residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing, requiring opposite gender announcements, justification and documentation requirements for all cross-gender strip searches, cross-gender visual body cavity searches, and cross gender pat-down searches.

Subsection (b): Facility policy 17.1 [IV-2] Limits to cross-gender viewing and searches requires that a Pat-down manual search of the juvenile's outer clothing by a staff member of the same gender as the juvenile. Another staff member of the same gender shall witness these searches. There have been no cross-gender pat searches as documented in the PAQ and verified through interviews with residents and staff.

Subsection (c): Facility policy 17.1 [IV-4] Limits to cross-gender viewing and searches requires all authorized searches to be justified and documented. There have been justify all cross-gender strip searches, cross gender visual body cavity searches, or cross-gender pat-down searches.

Subsection (d): Facility policy 17.1 [IV-5] Limits to cross-gender viewing and searches requires that all residents are able to shower, perform bodily functions, and change clothing without nonmedical staff viewing their genitals, buttocks, breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routing cell checks (including viewing via video camera and recordings). Unless there is an exigent circumstance staff of the opposite gender entering a unit will announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing. Staff will document on the unit log if an exigent circumstance occurred. The Auditor noted that during the tour of the facility physical plant, the PREA Coordinator and other staff made opposite gender announcements appropriately upon entering each of the housing units. Compliance was further confirmed through random staff and random resident interviews.

Subsection (e): Facility policy 17.1 [IV-6] Limits to cross-gender viewing and searches states that staff shall not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined during conversation with the resident, by reviewing medical records, or, if necessary by learning that information as a part of a broader medical exam conducted in private by a medical practitioner. This policy prohibits the search of a transgender or intersex resident for the sole purpose of determining the resident's genital status. Interviews with staff corroborate that they understand this policy and that is the practice of the facility. There were no identified transgender or intersex residents in the facility during the on-site audit. Compliance was confirmed through interviews with random residents.

Subsection (f): Facility policy 17.1 [IV-7] Limits to cross-gender viewing and searches requires that all security staff shall be trained how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. The Auditor confirmed that the facility had trained all staff on how to conduct pat-down searches of transgender and intersex residents in a professional and respectful manner and in the least intrusive manner possible. Training documentation was submitted to evidence this and interviews with staff indicate they could articulate proper search procedures for pat-down searches which are the only searches they are allowed to conduct. Interviews with random staff corroborated that no such searches had been conducted at

the facility.

Corrective Action: None

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. Agency policy 17.1 Prevention ;and Planning [V] Residents with disabilities and residents who are limited English proficient
2. Resident Handout – "Juvenile Rights and Rules While in Detention"
3. Resident Pamphlet – "Understanding the Prison Rape Elimination Act"
4. Resident Pamphlet – "End the Silence"
5. PREA Video
6. Training Curriculum/training logs related to disabled residents and residents with limited English proficiency
7. Language Line Services, Inc. Memorandum of Understanding, May 2016
8. Interviews with the following:
    a. random residents and
    b. random staff

Findings (By Subsection):

Subsection (a): Agency policy 17.1 [V-1] Residents with disabilities and residents who are limited English proficient has established procedures to provide disabled residents equal opportunity to participate in and benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The facility utilizes Language Line Services, Inc. for their translation needs. PREA posters are posted throughout the facility in Spanish as well as English. Resident Pamphlets are available in both English and Spanish.

Subsection (b): Agency policy 17.1 [V-2] Residents with disabilities and residents who are limited English proficient has established policies and procedures to provide residents with limited English proficiency equal opportunity to participate in and benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The facility has multiple staff members who speak Spanish and can assist with translation when necessary. External translation services are available through contracted services when needed.

Subsection (c): Agency policy 17.1 [V-3] Residents with disabilities and residents who are limited English proficient prohibits relying on resident interpreters, resident readers, or other types of resident assistant except in limited circumstances as required by this subsection. Interviews with staff corroborate this policy is the practice in the facility. There were no residents with disabilities or limited English proficiency at the

facility during the on-site audit.

Corrective Action: None.

Standard 115.317 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. Agency policy 17.1 Prevention and Planning [VI] Hiring and Promotion Prohibitions and Requirements
2. Completed Pre-Audit Questionnaire (PAQ)
3. Criminal History, Child Abuse Registry, and Prior Institutional Checks Spreadsheet (Employees and Contractors)
4. Reference Check Form PREA
5. Personnel files for current employees, new employees and employees receiving promotions
6. Volunteer/Contractor files
7. Interviews with the following:
   a. Agency Chief Juvenile Probation Officer,
   b. Facility Director,
   c. Human Resources staff,
   d. PREA Compliance Coordinator

Findings (By Subsection):

Subsection (a): Agency policy 17.1 Hiring and Promotion Prohibitions and Requirements [VI-A-C] provides that the agency will not hire, promote anyone or enlist contractor service providers who may have contact with residents who have engaged in any of the PREA standards prohibited criteria related to sexual abuse or sexual harassment. The facility policy regarding hiring and promotions is compliant with this standard. The facility utilizes the State of Texas Department of Public Safety fingerprint system (FAST) to perform new employee, contractor, volunteer, intern background checks as well as for anyone who may have contact with residents. The PREA Coordinator compiled a Criminal History, Child Abuse Registry, and Prior Institutional Checks Spreadsheet of employees and contractors presented to the Auditor which demonstrated compliance with this standard subsection. The Auditor further reviewed a sample of three (3) new employee files and one (1) employee promoted file and determined the facility is compliant with this standard subsection.

Subsection (b): Agency policy 17.1 Hiring and Promotion Prohibitions and Requirements [VI-2] requires the agency to consider of any incidents of sexual harassment in determining whether to hire or promote anyone or to enlist the services of any contractor who many have contact with residents.

Subsection (c): Agency policy 17.1 Hiring and Promotion Prohibitions and Requirements [VI-3 (A-D)] requires that a criminal background check and child abuse registry check be conducted for all new employees prior to hiring. The facility utilizes the State of Texas Department of Public Safety fingerprint system (FAST) to

accomplish that requirement. The Auditor reviewed an informational spreadsheet which tracks the checks and reviewed 3 (three) personnel files to corroborate that these checks had been done as required by policy. The facility requires prospective employees to disclose any prior institutional employers and all places the applicant has resided for the past 10 years. Interviews with Human Resources staff corroborate this practice.

Subsection (d): Agency policy 17.1 Hiring and Promotion Prohibitions and Requirements [VI-3 (A-D)] requires that a criminal background check and child abuse registry check be conducted for all contractors prior to their utilization. The Auditor reviewed an informational spreadsheet which tracks the background checks corroborated that these checks had been done as required by policy. The PAQ submitted by the facility reports that in the past 12 months, 13 persons were hired who may have contact with residents who had criminal background checks performed. Additionally, the auditor confirmed that one (1) contractor had criminal background check done in the past 12 months. Interviews with Human Resources staff corroborate this practice. The facility has a variety of contractors that provide services to the residents. Many of these contractors have professional licenses and criminal history checks are conducted by the licensing entity. Counselors are licensed by the Texas Department of State Health Services (TDSHS) and a criminal history check is done at the initial application for licensure, and during renewals every two years as specified in Texas Administrative Code, Title 22, Part 30, Section 681.121(a); TDSHS also conducts a random check process periodically. Additionally, the licensee is required to report any changes to criminal history as they occur. The Psychologists and Nurse Practitioner who work at the facility are licensed by The Texas State Board of Examiners of Psychologists. Texas Administrative Code, Title 22, Part 24, Section 463.7(b), states that the board will obtain updated criminal information from the Texas Department of Public Safety quarterly. The facility verifies that all professionally licensed staff is in good standing with their licensing entity.

Subsection (e): Agency policy 17.1 Hiring and Promotion Prohibitions and Requirements [VI (3) (D)] requires criminal background checks to be done every two (2) years for current employees and contractors. This practice exceeds this section of the standard. The Auditor reviewed three (3) personnel files of current staff and confirmed that the checks had been completed. The facility exceeds this subsection because it conducts criminal background checks every two (2) years rather than every five (5) years.

Subsection (f): Agency policy 17.1 [Hiring and Promotion Prohibitions and Requirements VI-4] requires the facility to ask all applicants and employees who may have contact with residents about the PREA related misconduct in this section in written applications or interviews for hiring or promotions and as part of employees' evaluation processes. Policy also requires the facility to impose upon employees a continuing affirmative duty to disclose any such misconduct and to report such conduct immediately (within 24 hours).

Subsection (g): Agency policy 17.1 Hiring and Promotion Prohibitions and Requirements [VI-5] states that material omissions regarding PREA-related conduct, or the provision of materially false information is grounds for termination.

Subsection (h): Agency policy 17.1 Hiring and Promotion Prohibitions and Requirements [VI-6] requires the Chief Juvenile Probation Officer or designee to provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work. Interviews with Human Resources staff confirmed this practice.

Corrective Action: None.

Standard 115.318 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

X Not Applicable

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

Evidence Reviewed (documents, interviews, site review):

1. Pre-Audit Questionnaire (PAQ)
2. Facility policy Upgrades to Facilities and Technologies – Upgrades to Facilities and Technology Policy
3. Interviews with the following:
   a. Agency Chief Juvenile Probation Officer,
   b. Facility Director

Findings (By Subsection):

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

Subsection (b): The facility has not installed or upgraded video monitoring systems, electronic surveillance system or other monitoring technology since its last audit.

Corrective Action: None.

Standard 115.321 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency Policy 17.2 Responsive Planning – Evidence Protocol
3. Written memorandum from Fort Bend County Sheriff's Office, Criminal Investigation Division agreeing to investigate all allegations of sexual assault within the Fort Bend County Juvenile Detention Center and to conduct the investigations through an investigative protocol that meets the standards as recommended in the National Protocol for Sexual Assault Medical Forensic Medical Examinations.
4. Written agreement with Fort Bend County Women's Center for victim assistance and counseling services.
5. Interlocal Agreement May between the Harris Health System and the Fort Bend County Juvenile Board

to provide forensic medical examinations.

6. Interviews with the following:
    a. Interviews with random staff, and PREA Compliance Coordinator
    b. Email communication with Fort Bend County Sheriff's Office Investigator Supervisor
    c. Telephone interview with Administrator Oak Bend providing SAFE/SANE services
    d. Random Staff
    e. Telephone interview with Fort Bend County Sheriff's Office Representative
    f. Telephone interview with Harris Health System Administrator providing SAFE/SANE services
    g. Telephone interview with Executive Director, Fort Bend County Women's Center

Findings (By Subsection):

Subsection (a): Agency policy 17.7 [I-II] states that the Fort Bend County Juvenile Probation Department is responsible for the only for the conduct of administrative investigations into allegations of sexual abuse. The facility policy outlines a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. Staff has been provided first responder card that contain the first responder protocol; these cards can be carried in the staff member's wallet or ID badge to help refresh memory if and when an acute incident occurs in the facility. Staff interviews demonstrated knowledge of the first responder's evidence protocol in the facility.

Subsection (b): The PREA Coordinator stated that the protocol is based on the U.S. Department of Justice's Office on Violence Against Women publication (or a similarly comprehensive and authoritative protocol which was confirmed by the Auditor.

Subsection (c): A written agreement completed with the Harris Health System and the Fort Bend County Juvenile Services Department provides for forensic medical examinations offered to residents without financial cost to the residents. A telephone call was placed to the Administrative Director, Risk Management and Patient Safety Department, Forensic Nursing Services to ask for confirmation, but was not able to speak with the Administrative Director. The Auditor reviewed an email from the Administrative Director which documented that the Harris Health System would provide the required services.

Subsection (d) and (e): Victim advocates are available through the Fort Bend County Women's Center which provides rape crisis hotlines and counseling services for victims and victim support. The facility has an agreement in place with the Fort Bend County Women's Center to provide victim advocacy services to residents that are victims of sexual abuse. There are qualified staff members at the Fort Bend County Juvenile Detention Center who can provide crisis intervention and accompany/support the resident through the forensic medical examination processes/interviews, emotional support, crisis intervention, information and referrals, if requested by the resident. Interviews with the PREA Compliance Coordinator and Fort Bend County Women's Center confirmed the written agreement between the Fort Bend County Women's Center and the facility. There had been no residents who reported sexual abuse.

Subsection (f): Agency Policy 17.7 Investigations [I-1] states that the Fort Bend County Sheriff's Office shall conduct all criminal investigations of allegations of sexual abuse and sexual harassment. The facility has requested the Fort Bend County Sheriff's Office to follow the requirements of this PREA standard 115.321 subsections (a) through (e). The Fort Bend County Sheriff's Office agreed through a MOU with facility they will conduct all criminal investigations. The MOU requires the Fort Bend County Sheriff's Office to use a protocol developed based on a nationally recognized protocol based on the Department of Justice Office on Violence against Women protocol or similarly comprehensive and authoritative protocol developed after 2011. The Auditor conducted a telephone interview with the Fort Bend County Sheriff's Office who confirmed the agreement as well as the protocol to be utilized.

Corrective Action: None.

Standard 115.322 Policies to ensure referrals of allegations for investigations

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

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency Policy 17.7 Investigations [I][II-C] Criminal Investigations
3. Fort Bend County Juvenile Detention Center website link **http://www.fortbendcountytx.gov/index.aspx?page=1814**
4. Interviews with Assistant Chief Juvenile Probation Officer, PREA Manager, facility investigator staffs and Fort Bend County Sheriff's Office Investigator
5. Interviews with the following:
    a. Agency Head
    b. Facility investigative staff

Findings (By Subsection):

Subsection (a): Agency Policy 17.7 Investigations [I]ensures that administrative investigations are completed for all allegations of sexual abuse and sexual harassment. The PAQ documents that the facility had zero (0) allegations since the last PREA audit.

Subsection (b) and (c): Agency Policy 17.7 Investigations [II-C] states that the facility ensures that an administrative and/or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. Criminal cases are referred to the Fort Bend County Sheriff's Office that has the legal authority and responsibility to investigate all incidents occurring in the facility. The facility publishes this policy on its website link **http://www.fortbendcountytx.gov/index.aspx?page=1814** as observed by the Auditor. Interviews with facility investigative staff indicate this is the practice of the facility.

Corrective Action: None.

Standard 115.331 Employee training

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

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

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency policy 17.3 Training and Education – [I] Employee Training
3. NIC PREA Training Curriculum: training provided by TJJD
4. Fort Bend County Juvenile Services Staff Training Acknowledgement Form
5. PREA Training Curriculum
    a. Unit 1: Overview of your Roles and Responsibilities
    b. Unit 2: Juvenile Rights
    c. Unit 3.1: Prevention, Detection of Sexual Abuse and Sexual Harassment
    d. Unit 3.2: Response and Reporting of Sexual Abuse and Sexual Harassment
    e. Unit 4: Professional Boundaries
    f. Unit 5: Effective and Professional Communication with Juveniles
6. PREA training spreadsheet
7. Interviews with the following:
    a. Random Staff

Findings (By Subsection):

Subsection (a): Agency policy 17.3 Training and Education - [I-1] Employee Training requires all employees who may have contact with residents shall receive, during orientation, training on the 11 elements required by this subsection. The Auditor reviewed the training materials used to verify all topics were addressed. The Facility has a strong training for new employees on PREA policies, procedures and facility practices. The PREA Coordinator has done an excellent job on the Facility PREA training program utilizing comprehensive curriculum and trainings.

Subsection (b): Agency policy 17.3 Training and Education - [I-2] Employee Training provides for training which tailored to the gender of the residents and to the unique needs and attributes of residents of juvenile facilities. Fort Bend County Juvenile Detention Center is co-ed facility. All employees are trained to work with both male and female residents.

Subsection (c): Agency policy 17.3 Training and Education - [I-3] Employee Training requires initial PREA training utilizing the PREA Training Curriculum Units 1-5 identified above. Training and frequent on-going refresher training has been provided as required by this subsection. The facility reports in the PAQ that 206 staffs have been trained and retrained in PREA related issues. A PREA Training spreadsheet had been created which tracks all employees of training that is received annually.

Subsection (d): Following completion of all PREA training, all employees are required to sign a statement that they understood the training provided. Documentation of such training and evidence of understanding are maintained in the employee's files. The Auditor reviewed a random sample of three (3) training files to verify training for new staff as well as tenured staff.

Corrective Action: None.

Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency policy 17.3 Training And Education - [II] Volunteer, Vendor and Contractor Training
3. Employee /Volunteer/Intern/Contractor Training and Acknowledgement
4. Volunteer and Contractors training guide entitled "A Guide for the Prevention and Reporting of Sexual Abuse with Residents
5. PREA Training Curriculum and Materials
6. Volunteer and Contractor Training Tracking Spreadsheet
7. Volunteer and Contractor Training Records

Findings (By Subsection):

Subsection (a): Agency policy 17.3 [II] Volunteer, Vendor and Contractor Training requires all contractors and volunteers that have contact with residents are trained on their responsibilities under the facility's PREA policies and procedures regarding sexual abuse and sexual harassment prevention, detection and response. In the PAQ, the facility reports that 78 volunteers and four (4) contractors have been trained on PREA. A training tracking spreadsheet demonstrated this training having been conducted. There were no volunteer or contractors available for interview during the audit.

Subsection (b): Agency policy 17.3 [II] Volunteer, Vendor and Contractor Training provides that the level and type of training provided to volunteers and contractors are based on the services they provide and the level of contact they have with residents. All volunteers and contractors who have contact with residents had been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and how to report such incidents.

Subsection (c): Agency policy 17.3 [II] Volunteer, Vendor and Contractor Training requires the facility to maintain documentation confirming that volunteers/contractors understand the training they have received. The Auditor noted that volunteers and contractors had been given pre/post-tests to further document their understanding of the training. The PREA Coordinator provided training documentation with signatures of volunteers and contractors acknowledging that they understand the training they received. There were no volunteers or contractors available for interview.

Corrective Action: None.

Standard 115.333 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

information on specific corrective actions taken by the facility.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency policy 17.3 Training and Education – [III] Resident Education
3. PREA Unit Orientation Form with resident signature
4. Youth Admission Pamphlet (English and Spanish) – "A Guide to Residents' Rights and Reporting Under PREA"
5. Youth Handout (English and Spanish) "Understanding the Prison Rape Elimination Act"
6. Facility PREA posters
7. Spreadsheet date of residents' admission and date of receipt of the required information
8.
9. Resident Education Materials
    a. Residents Orientation Pamphlet
    b. Safeguarding Your Sexual Safety (PREA Video)
    c. PREA posters and signage
10. Resident Files
11. Observation of signage and educational materials on display in facility housing units and programming areas during tour of physical plant
12. Interviews with the following:
    d. Intake Staff
    e. Random Residents

Findings (By Subsection):

Subsection (a): Agency policy 17.3 – Resident Education [III-1] requires that residents receive information at the time of intake about the zero-tolerance policy regarding sexual abuse and sexual abuse and how to report incidents or suspicions of sexual abuse or sexual harassment. The facility utilizes a variety of resident acknowledgement forms to document and evidence the provision of this training to residents. The PAQ documents that in the past 12 months, 587 residents were provided PREA education at intake. The PREA Coordinator presented a spreadsheet which noted date of residents' admission and date of receipt of the required information demonstrating compliance.

Subsection (b): Agency policy 17.3 – Resident Education [III-2] requires that within 10 days of intake, the facility shall provide comprehensive age-appropriate PREA education to residents. This facility exceeds this subsection as it provides comprehensive PREA education to residents upon intake and each weekday morning on the living units. The facility utilizes the Safeguarding Your Sexual Safety video. Residents view the video in either English or Spanish. The facilitator uses a modified instructor's guide to cover the material as it relates to Fort Bend County. The PREA Coordinator provided a spreadsheet documenting all residents' receipt of this required education. Three (3) resident files were reviewed randomly by the Auditor to verify the comprehensive education was occurring in a timely fashion. It was that documented that all residents had received PREA comprehensive resident education upon admission to the facility.

Subsection (c): Agency policy 17.3 – Resident Education [III-3] requires all residents to receive the PREA training. Residents are not transferred between programs in the facility. The PREA Coordinator presented a spreadsheet which noted date of residents' admission and date of receipt of the required information demonstrating compliance.

Subsection (d): Agency policy 17.3 – Resident Education [III-4] requires that resident PREA education is available in assessable formats for all residents including those who are limited English proficient, deaf, visually impaired, or otherwise disabled as required by this subsection. The facility has interpreting services available, staff that are bilingual and materials in English and Spanish throughout the facility. If additional accommodation is needed, the appropriate community resource will provide for that service.

Subsection (e): Agency policy 17.3 – Resident Education [III-5] requires the facility to maintain documentation of resident participation in PREA training. Residents must sign an acknowledgement form stating they have received the training and understand it. The Auditor reviewed the tracking spreadsheet as verification of resident participation in such training. The Auditor reviewed three (3) random resident files to corroborate this documentation was present. Interviews with residents further evidenced the training is occurring as residents are able to state the meaning of zero tolerance and the reporting mechanisms available to them to report abuse.

Subsection (f): Agency policy 17.3 – Resident Education [III-6] requires key PREA information is continuously and readily available to residents through posters, signage, resident Pamphlet s or other written formats. During the tour, the Auditor observed PREA posters throughout the facility in both English and Spanish. All housing units have signage with key phone numbers and addresses of entities to whom the resident can report or contact for services.

Corrective Action: None.

Standard 115.334 Specialized training: Investigations

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

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency policy 17.3 Training and Education- [IV] Specialized Training: Investigators
3. Specialized Training: Investigating Sexual Abuse in Correctional Settings Training for Trainers – Curriculum
4. Written memorandum from Fort Bend County Sheriff's Office, Criminal Investigation Division agreeing to investigate all allegations of sexual assault within the Fort Bend County Juvenile Detention Center
5. Interviews with the following:
   a. Investigative Staff
6. Training documentation for Investigators

Findings (By Subsection):

Subsection (a): Agency policy 17.3 - Specialized Training: Investigators [IV 1] requires that in addition to the general training provided to all employees, all investigators must also receive specialized training in conducting sexual abuse investigations in confinement settings. The facility has two (2) individuals that have completed the PREA Resource Center Training for Trainers – Specialized Training: Investigating Sexual abuse in Correctional Settings conducted by The Moss Group, Inc. sponsored by the National PREA Resource Center. The Auditor was provided with Certificates of Attendance for the two (2) employees who earned certificates by attending three (3) day training. An interview with a facility investigator corroborates this training was completed.

Subsection (b): Agency policy 17.3 - Specialized Training: Investigators [IV 2] requires that the specialized training include the topics detailed in this subsection. The Curriculum Specialized Training: Investigating

Sexual Abuse in Correctional Settings Training for Trainers – Curriculum was reviewed by the Auditor and determined it to be compliant with this requirement.

Subsection (c): Agency policy 17.3 - Specialized Training: Investigators [IV 3] requires the facility to maintain documentation that investigators have completed the required specialized training. The Auditor was provided documentation to substantiate compliance.

Subsection (d): Agency policy 17.3 - Specialized Training: Investigators [IV 4] requires any State entity or Department of Justice component that investigates sexual abuse in juvenile confinement settings shall provide such training to its agents and investigators who conduct such investigations.

Corrective Action: None.

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency policy 17.3 Training and Education – [V] Specialized Training: Medical and Mental Health Care National Institute of Corrections (NIC) Web-based Training
3. Medical and Mental Health Care staff Certificate of Completion – PREA: Your Role
4. Training documentation for Medical and Mental Health Staff
5. Interviews with the following:
    a. Medical Staff

Findings (By Subsection):

Subsection (a): Agency policy 17.3 – [V-1] Specialized Training: Medical and Mental Health Care requires the facility to train all full and part-time medical and mental health care practitioners who work regularly in the facility on PREA. The facility reports that there are 12 medical and mental health practitioners at the facility and 12 have received this training. The auditor interviewed the medical staff at the facility and confirmed the receipt of the required training.

Subsection (b): Agency policy 17.3 – [V-1] Specialized Training: Medical and Mental Health Care prohibits medical staff employed by the facility from conducing forensic medical exams. This subsection is therefore not applicable.

Subsection (c): Agency policy 17.3 – [V-2] Specialized Training: Medical and Mental Health Care Facility policy requires the facility to maintain documentation that medical and mental health staff has received the specialized training required by this standard. The Auditor was provided with the documentation of the mandatory training completion for 12 medical and mental health practitioners.

Subsection (d): Agency policy 17.3 – [V-3] Specialized Training: Medical and Mental Health Care requires that all medical and mental health care practitioners at the facility also receive the training mandated for all employees. Training documentation was provided for all practitioners.

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency Policy 17.4 Screening for Risk of Sexual Victimization and Abusiveness- Obtaining Information from Residents
3. Fort Bend County Juvenile Detention Center – Intake Screening for Potential Sexual Aggressive Behavior and/or Sexual Victimization
4. Spreadsheet documenting all resident screening
5. Interviews with the following:
    a. Random Residents
    b. Staff Responsible for Risk Screening
    c. PREA Coordinator
6. Resident Files (Reviewing screening/assessment documentation)

Findings (By Subsection):

Subsection (a): Agency Policy 17.4 - Obtaining Information from Residents [I-1] requires that a resident have a vulnerability assessment conducted within 72 hours of the resident's arrival at the facility and periodically throughout a resident's confinement. The facility reports in the PAQ that during the past 12 months, 367 youth whose length of stay was for 72 hours or more were screened for risk of sexual victimization or sexual aggression. The Auditor reviewed resident files to determine if the vulnerability assessment was occurring within 72 hours and all files reviewed were compliant. The screening occurs on the same day of admission. The facility exceeds this subsection of the standard.

Subsection (b): Agency Policy 17.4 - Obtaining Information from Residents [I-2] requires the facility to use an Objective Screening Instrument (Screening for Risk of Sexual Victimization and Abusiveness).

Subsection (c): Agency Policy 17.4 - Obtaining Information from Residents [I-3] requires the facility assessment process to attempt to ascertain information about 11 specific types of information enumerated by this standard. The objective screening instrument used by the facility complies with this section. Interviews with staff indicate they are complying with this standard.

Subsection (d): Agency Policy 17.4 - Obtaining Information from Residents [I-4] requires staff to ascertain the information required by this standard through conversations with the resident during intake and medical and mental health screenings, during classification assessments and by review of relevant records of the youth. Interviews with staff indicate they are complying with this standard.

Subsection (e): Agency Policy 17.4 - Obtaining Information from Residents [I-5] requires the facility to ensure that sensitive information gained during the assessment process is kept confidential and only disclosed to staff with the need to know. All information gained in the assessment/screening process is kept confidential and only staff with a need to know can access this data. The facility utilizes the Juvenile Case Management System (JCMS) for their automated record system. JCMS has role-based security protocols that help facility administration ensure that information is only accessed by those with a need to know and who have been given appropriate authorization and access.

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Policy Agency Policy 17.4 II Screening for Risk of Sexual Victimization and Abusiveness - Placement of residents in housing, bed, program, education, and work assignments
3. Fort Bend County Juvenile Detention Center INTAKE BEHAVIORAL SCREENING Form
4. Interviews with the following:
    a. Facility Director
    b. Staff Responsible for Risk Screening
    c. Medical and Mental Health Staff
5. Resident Files

Findings (By Subsection):

Subsection (a): Policy Agency Policy 17.4 – [II-1] Screening for Risk of Sexual Victimization and Abusiveness - Placement of residents in housing, bed, program, education, and work assignments requires staff to make housing, bed, program, education, and work assignments for residents based on the information obtained in the screening process under Standard 115.341. Interviews with risk screening staff and review of resident files corroborate this policy is the practice of the facility.

Subsection (b): Policy Agency Policy 17.4 [II-2] Screening for Risk of Sexual Victimization and Abusiveness - Placement of residents in housing, bed, program, education, and work assignments states that residents will be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged. During any period of isolation, FBCJPC shall not deny residents daily large-muscle exercise and any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible. Interviews with a variety of staff corroborate that isolation is not used for residents at risk of sexual victimization.

Subsection (c): Policy Agency Policy 17.4 [II-3] Screening for Risk of Sexual Victimization and Abusiveness - Placement of residents in housing, bed, program, education, and work assignments states prohibits placing

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

Subsection (d): Policy Agency Policy 17.4 [II-4] Screening for Risk of Sexual Victimization and Abusiveness - Placement of residents in housing, bed, program, education, and work assignments states that a transgender or intersex resident's own view with respect to his/her own safety shall be given serious consideration. Staff making housing and programming assignments for transgender or intersex residents in the facility will be on a case-by-case basis and will require final approval from the Facility Administrator. During the on-site audit, there were no identified transgender or intersex residents at the facility during the audit. Interviews with staff indicate that housing and programming assignments is made on a case-by-case.

Subsection (e): Policy Agency Policy 17.4 [II-5] Screening for Risk of Sexual Victimization and Abusiveness - Placement of residents in housing, bed, program, education, and work assignments states that placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident. During the on-site audit, there were no identified transgender or intersex residents at the facility during the audit.

Subsection (f):): Policy Agency Policy 17.4 [II-6] Screening for Risk of Sexual Victimization and Abusiveness - Placement of residents in housing, bed, program, education, and work assignments requires staff to give serious consideration to a transgender or intersex resident's own views with respect to his or her safety. Interviews with screening staff indicate this would be the practice when the facility has a transgender or intersex resident. Interviews with risk screening staff verified this as the policy which would be followed. During the on-site audit, there were no identified transgender or intersex residents at the facility during the audit.

Subsection (g): Policy Agency Policy 17.4 [II-7] Screening for Risk of Sexual Victimization and Abusiveness - Placement of residents in housing, bed, program, education, and work assignments provides that transgender and intersex residents shall have the opportunity to shower separately from other residents. Interviews with staff confirm this to be the practice as necessary. Interviews with staff indicated that additional precautions would be made for transgender or intersex residents to ensure the residents have complete privacy and that these residents would be brought to shower one at a time. Interviews with risk screening staff verified this as the policy which would be followed. During the on-site audit, there were no identified transgender or intersex residents at the facility during the audit.

Subsection (h): Policy Agency Policy 17.4 [II-8] Screening for Risk of Sexual Victimization and Abusiveness - Placement of residents in housing, bed, program, education, and work assignments requires documentation of any residents placed in isolation including the basis for the isolation and the reason why no alternative means of separation could be achieved. The facility reports that in the past 12 months, there have been no residents at risk for sexual victimization placed in isolation.

Subsection (i): Policy Agency Policy 17.4 [II-9] Screening for Risk of Sexual Victimization and Abusiveness - Placement of residents in housing, bed, program, education, and work assignments requires that if a resident is at risk of sexual victimization and held in isolation, the facility will afford each such resident a review every 30 days by the facility administrator and supervisor to determine whether there is a continuing need for separation from the general population. The facility reports that in the last 12 months there have been no residents at risk for sexual victimization placed in isolation.

Corrective Action: None.

Standard 115.351 Resident reporting

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

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency Policy 17.5 [I]Reporting - Resident Reporting
3. Agency posting of multiple internal and external reporting telephone numbers of sexual abuse or sexual harassment (English and Spanish)
4. Youth Admission Pamphlet (English and Spanish) – "A Guide to Residents' Rights and Reporting Under PREA"
5. Youth Handout (English and Spanish) "Understanding the Prison Rape Elimination Act"
6. Facility posting of multiple internal and external reporting telephone numbers of sexual abuse or sexual harassment (English and Spanish)
7. Resident Orientation Pamphlet (English and Spanish) "A RESIDENT'S GUIDE TO SUCCESS IN THE FORT BEND COUNTY JUVENILE DETENTION CENTER"
8. Facility PREA Video
9. Staff PREA Training Curriculum
10. Interviews with the following:
    a. facility PREA Compliance Coordinator,
    b. random staff and residents
    c. observation of facility programs,
    d. housing units and programming areas during tour of physical plant noting PREA posters, signage and educational materials on display or readily accessible

Findings (By Subsection):

Subsection (a): Agency Policy 17.5 Reporting – [I-1] Resident Reporting states that the agency shall provide multiple internal methods to privately report sexual abuse and sexual harassment, retaliation by other residents or staff and staff neglect or violation of responsibilities that may have contributed to such incidents. A resident may report these issues by verbally telling a staff member and/or by using the facility's grievance process. A review of the Facility PREA video, Youth Handout, Youth Admission Pamphlet and prominent posting throughout the housing units and other locations indicated the multiple internal ways for residents to privately report all concerns required by this standard. Interviews with residents indicate that they understand their reporting options as a result of PREA education, posters, and signage. Residents could state the different ways to report sexual abuse and sexual harassment, retaliation or staff neglect/responsibility negligence. Staff interviews indicated that residents understand and know the various mechanisms.

Subsection (b): Agency Policy 17.5 Reporting – [I-1] Resident Reporting identifies at least one way for residents to privately and anonymously report sexual abuse of sexual harassment to an external entity not affiliated with the agency identified as to the Texas Juvenile Justice Department (TJJD) abuse reporting phone line and/or to the Fort Bend County Sheriff's Department. The TJJD toll-free phone number and the

phone number to the Fort Bend County Sheriff's Department are found on PREA posters throughout the facility common areas and housing areas. Interviews with residents demonstrate they understand they can call the hotline and how to request staff to allow them to use the phone. Residents are not detained solely for civil immigration purposes.

Subsection (c): Agency Policy 17.5 Reporting – [I-2] Resident Reporting requires facility staff to accept reports made verbally, in writing, anonymously, and from third parties and required to immediately, without delay report any verbal a reports or a witness statement. Staff is required and follows mandatory reporting duties. Interviews with facility staff indicate their knowledge of and adherence to this policy and practice. Interviews with residents knew how to make reports verbally, in writing, anonymously and through third parties.

Subsection (d): Agency Policy 17.5 Reporting – [I-3] Resident Reporting requires that residents shall have access to tools necessary to make a written report. Grievance forms are available from staff members and available in common areas. Facility policy requires staff will ensure blank grievance forms are available at all times to residents. The Auditor observed grievance forms and grievance deposit boxes during the tour of the facility housing units and common areas. Interviews with residents demonstrated their understanding of the available reporting mechanisms such as the grievances.

Subsection (e): Agency Policy 17.5 Reporting – [I-4] Resident Reporting provides that staff can privately report sexual abuse and sexual harassment of residents by reporting to the Chief Juvenile Probation Officer, TJJD, direct supervisor, shift supervisor, shift manager, PREA Coordinator or to the Facility Administrator. Any such report must be immediately reported to the Facility Administrator. Random staff interviews demonstrated that staff understands private ways to report sexual abuse and sexual harassment of residents.

Corrective Action: None.

Standard 115.352 Exhaustion of administrative remedies

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

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency Policy 17.5 Reporting, II Resident Reporting - Exhaustion of Administrative Remedies
3. Grievance Forms available at facility website : http://www.fortbendcountytx.gov/index.aspx?page=1814
4. Residents Handout "Juvenile Rights and Rules While in Detention"
5. Interviews with the following:
    a. No Resident had reported sexual abuse
6. Observation of resident grievance forms and grievance boxes located in facility programs, housing units and programming areas during tour of physical plant

Findings (By Subsection):

Subsection (a): Agency Policy 17.5 Reporting - [II] Exhaustion of Administrative Remedies has an administrative procedure for dealing with resident grievances regarding sexual and is not exempt from this standard. The PAQ documents that the facility reports that there have been no grievances filed alleging sexual abuse. During the facility on-site review, the Auditor observed placement of grievance forms in the housing units as well as secure grievance deposit boxes throughout the facility available to residents.

Subsection (b): Agency Policy 17.5 Reporting - [II] [1-4] Exhaustion of Administrative allows a resident to submit a grievance regarding an allegation of sexual abuse at any time regardless of when the incident is alleged to have occurred. Residents are not required to comply with the grievance procedures involving informal attempts to resolve issues for any grievance alleging sexual abuse or sexual harassment. Residents are not required to try to resolve with staff an alleged incident of sexual abuse. This information is provided to the residents in the Resident's Orientation Handbook.

Subsection (c): Agency Policy 17.5 Reporting - [II] [5-6] Exhaustion of Administrative Facility prohibits the facility from requiring residents to submit a grievance alleging sexual abuse or sexual harassment to a staff member who is the subject of the complaint. The facility shall not refer the grievance to the individual who is the subject of the complaint. Policy is compliant with this subsection and staff interviews confirmed the practice which could be used.

Subsection (d): Agency Policy 17.5 Reporting - [II] [7-10] Exhaustion of Administrative requires a decision on the merits of a grievance alleging sexual abuse or sexual harassment within 90 days of the initial filing of the grievance as required by this subsection. Policy is compliant with this subsection and staff interviews confirmed the practice which could be used. There were no residents who reported a sexual abuse.

Subsection (e): Agency Policy 17.5 Reporting - [II] [11-14] Exhaustion of Administrative permits third parties, including fellow residents, staff members, family members, attorneys, etc. to assist residents in filing requests for administrative remedies as required by this subsection. Policy is compliant with this subsection and staff interviews confirmed the practice which could be used. Interviews with residents confirmed they knew outside parties could help them file a grievance. There had been no third-party reports.

Subsection (f): Agency Policy 17.5 Reporting - [II-15] Exhaustion of Administrative provides for an emergency grievance procedure for residents to report situations involving imminent risk of sexual abuse of a resident. Policy is compliant with the requirements of the subsection regarding timelines for resolution. The emergency grievance procedure is explained during the resident comprehensive education component. The resident education materials (i.e., handout, orientation documents) discuss PREA and the grievance procedure. Policy is compliant with this subsection and staff interviews confirmed the practice which could be used. There had been no emergency grievances filed.

Subsection (g): Agency Policy 17.5 Reporting - [II-16] Exhaustion of Administrative states that it may discipline a resident for filing a grievance related to alleged sexual abuse only where the facility demonstrates that the resident filed the grievance in bad faith. The facility had no documented instances of discipline of residents for bad faith grievances. Policy is compliant with this subsection and staff interviews confirmed the practice which could be used. There had been no resident disciplined for filing an allegation of sexual abuse.

Corrective Action: None

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. Agency Policy 17.5 Resident Reporting - [III] Resident Access to Outside Confidential Support Services and Legal Representation
2. Agency agreement between the Fort Bend County Juvenile Board and the Fort Bend County Women's Center
3. Resident Handout "Juvenile Rights and Rules While in Detention"
4. Youth Admission Pamphlet (English and Spanish) – "Youth Safety Guide for Juvenile Services"
5. Resident Detention Pamphlet (English and Spanish) "A Guide to Residents' Rights and Reporting Under PREA"
6. Observation of signage and educational materials on display in facility programs (secure and non-secure), housing units and programming areas during tour of physical plant
7. Facility PREA video
8. Facility PREA posters
9. Interviews with the following:
    a. Facility Director
    b. Random Residents
    c. Residents who Reported a Sexual Abuse
    d. Executive Director, Fort Bend County Women's Center

Findings (By Subsection):

Subsection (a): Agency Policy 17.5 - [III-1] Resident Access to Outside Confidential Support Services and Legal Representation provides that residents have access to outside victim advocates for emotional support services related to sexual abuse. Residents are informed of these services during the comprehensive education training and through signage in living units. Interviews with residents indicate that the youth understand how to access these services, who provides these services or what these services include.

Subsection (b): Agency Policy 17.5 - [III-2] Resident Access to Outside Confidential Support Services and Legal Representation provides that staff inform residents that conversations and written correspondence may be monitored for the purposes of ensuring safety and security within the facility.

Subsection (c): Agency Policy 17.5 - [III-3] Resident Access to Outside Confidential Support Services and Legal Representation provides that the facility to have agreements with community service providers for confidential emotional support for residents related to sexual abuse. The Fort Bend County Juvenile Services Department has agreements with the Fort Bend County Women's Center. The Auditor spoke to the Fort Bend County Women's Center and confirmed the agreement to provide the services required by this standard.

Subsection (d): Agency Policy 17.5 - [III-4] Resident Access to Outside Confidential Support Services and Legal Representation provides residents with reasonable and confidential access to their attorneys or other legal representatives and reasonable access to parents or legal guardians. Interviews with residents indicate the facility complies with these requirements.

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Facility Policy 17.5 IV Third Party reporting
3. Agency Posting of "Multiple Ways to Report"
4. Fort Bend County Juvenile Services Juvenile, Parent, Community Grievance Report Form
   Agency public website regarding Third Party Reporting made available on the agency's website– http://www.fortbendcountytx.gov/modules/showdocument.aspx?documentid=37355
5. Interview with the following
   a. Director of Fort Bend County Women's Center

Findings (By Subsection):

Subsection (a): Agency Policy 17.5 - [IV] Resident Access to Outside Confidential Support Services and Legal Representation provides mechanisms to receive third-party reports of sexual abuse and sexual harassment and distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident. Third parties can file a grievance on behalf of a resident and allege sexual abuse or sexual harassment. Third parties can also make a report of sexual abuse to the Director of Fort Bend County Women's Center and to the Fort Bend County Sheriff's Department. The Fort Bend County Juvenile Services Department website contains information on how to report as required by this standard.

Corrective Action: None.

Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire
2. Agency Policy 17.6 Official Response Following a Resident Report – [I] Staff and Agency Reporting Duties
3. Agency Policy 17.7 Investigations

4. Interviews with the following:
    a. Random Staff
    b. Medical Staff
    c. Facility Director

Findings (By Subsection):

Subsection (a): Agency Policy 17.7 [First Paragraph] Investigations requires staff to report immediately any knowledge, suspicion or information received regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency, retaliation against residents or staff or staff who reported an incident and any staff neglect or violations of responsibilities that may have contributed to an incident or retaliation. Interviews with staff demonstrate their knowledge of their reporting responsibilities under Texas law, facility policy and PREA regulations. Interviews and the PAQ corroborated that there had been no allegations of sexual abuse or sexual harassment at the facility.

Subsection (b): Agency Policy 17.6 [I-1] Staff and Agency Reporting Duties require all staff to comply with mandatory child abuse reporting laws. Random staff interviews confirmed their responsibility to comply with facility policies and mandatory child abuse reporting laws.

Subsection (c): Agency Policy 17.6 [3] Staff and Agency Reporting Duties requires that apart from reporting to the designated supervisors or officials and designated State or local services agencies, all staff to maintain that information in confidence except as necessary to make treatment/investigation and other security/management decisions.

Subsection (d): Agency Policy 17.6 [4-5] Staff and Agency Reporting Duties requires medical and mental health staff to report abuse to designated supervisors and officials. As well as to the designated State or local services agency where required by mandatory reporting laws. Medical and mental health practitioners are required to inform residents of the limitations of confidentiality of their duty to report and the limitations of confidentiality. Interviews with medical and staff confirm compliance with this standard relating to protection of confidential information and required disclosures. There was no mental health staff available for interview.

Subsection (e): Agency Policy 17.6 [6-8] Staff and Agency Reporting Duties requires the facility administrator or designee to promptly report the allegation to the PREA Coordinator, Chief PO, and the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified. If the victim is under the guardianship of DFPS the report shall be made to the caseworker instead of the parents or legal guardians. The allegation will also be reported to the victim's attorney or the youth's Juvenile Probation Officer within 14 days of receiving the allegation**.** Interviews with the PREA Compliance Coordinator and Facility Superintendent confirm practice follows policy.

Subsection (f): Agency Policy 17.6 [9] Staff and Agency Reporting Duties requires the facility to report all allegations of sexual abuse and sexual harassment, including third-part and anonymous reports to the PREA Coordinator/Investigator. Interviews with the Facility Administrator confirmed this is the practice.

Corrective Action: None.

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. Agency Policy 17.6 Official Response Following a Resident Report –(IV) Agency Protection Duties
2. Interviews with the following:
    a. Executive Director/Chief Juvenile Probation Officer
    b. Facility Director
    c. Random Staff

Findings (By Subsection):

Subsection (a): Agency Policy 17.6 Official Response Following a Resident Report – (II-4) Agency Protection Duties requires that when staff learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident. Staff shall take action to assess and implement appropriate protective measures without unreasonable delay. The administrator will take steps to separate the alleged victim from the alleged perpetrator. The alleged staff or resident abuser will not have contact with the victim. The PAQ documents that there have been no instances of this in the past 12 months. Interviews demonstrate all necessary actions to protect the resident would be taken immediately.

Corrective Action: None.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency Policy 17.6 Official Response Following a Resident Report – III Reporting to Other Confinement Facilities
3. Interviews with the following:
    a. Executive Director/Chief Juvenile Probation Officer
    b. Facility Director

Findings (By Subsection):

Subsection (a): Agency Policy 17.6 [III-1] Reporting to Other Confinement Facilities requires that upon receiving an allegation that a resident was sexually abused while in another confinement facility, the Facility Administrator

must notify the administrator of the facility or appropriate office of the agency where the alleged abuse occurred and shall notify the appropriate investigative agency. The PAQ documents that the facility reports that there have been zero (0) allegations of this type received in the past 12 months. Further the PAQ also states that the facility has received no notifications from other facilities in the past 12 months.

Subsection (b): Agency Policy 17.6 Official Response Following a Resident Report – [III-2] Reporting to Other Confinement Facilities requires that such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegations.

Subsection (c): Agency Policy 17.6 Official Response Following a Resident Report – [III-3] Reporting to Other Confinement Facilities requires that the Facility Administrator will document the notification and also notify TJJD.

Subsection (d): Agency Policy 17.6 Official Response Following a Resident Report – [III-4] Reporting to Other Confinement Facilities states that should the facility that receive such notification, it shall ensure the allegation is investigated in accordance with policy. Interviews with the Executive Director/Chief Juvenile Probation Officer and Detention Center Director confirm knowledge of this policy and stated that the policy would be followed should this situation occur.

Corrective Action: None.

Standard 115.364 Staff first responder duties

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

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency Policy 17.6 Official Response Following a Resident Report – [IV] Staff first responder duties
3. Staff training documents – training on first responder duties and responsibilities
4. Facility First Responder laminated card
5. Interviews with the following:
    a. Staff First Responders
    b. Random Staff

Findings (By Subsection):

Subsection (a): Agency Policy 17.6 Official Response Following a Resident Report – [IV-1] Staff first responder duties correctly identifies first responder duties upon receiving an allegation that a resident was sexually abused as required by this standard. The PAQ documents that there have been no allegations of sexual abuse in the facility during the past 12 months. Interviews with staff demonstrated their knowledge of the first responder protocol. The Facility has provided staff with first responder cards that staff can carry in their wallet or ID badge to use when responding to an incident. Interviews with staff indicate an understanding of their first responder

duties and an ability to articulate and explain the duties correctly. There were no residents who reported a sexual abuse.

Subsection (b): Agency Policy 17.6 Official Response Following a Resident Report – [IV-2] Staff first responder duties distinguishes the first responder duties for security staff versus non-security staff. Interviews with random staff confirmed knowledge of their responsibilities.

Corrective Action: None.

Standard 115.365 Coordinated response

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

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Fort Bend County Institutional Plan - Fort Bend County PREA First Responders Checklist and Coordinated Response
3. Interview with the following:
    a. Facility Director

Findings (By Subsection):

Subsection (a): Fort Bend County Institutional Plan - Fort Bend County PREA First Responders Checklist and Coordinated Response explains the manner in which the facility's coordinated written institutional response plan operates to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership. Interviews with the Detention Center Director and PREA Coordinator confirmed the details of the written plan.

Corrective Action: None.

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

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

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the Auditor's analysis and reasoning, and the Auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Interviews with the following:
    a. Executive Director/Chief Juvenile Probation Officer

Findings (By Subsection):

Subsection (a): This standard is not applicable. Fort Bend County Juvenile Services does not participate in any collective bargaining agreements. Texas is an "at-will" employment state and Fort Bend County Juvenile Services Department staff members are not unionized.

Subsection (b): This standard is not applicable. Fort Bend County Juvenile Services does not participate in any collective bargaining agreements. Texas is an "at-will" employment state and Fort Bend County Juvenile Services Department staff members are not unionized.

Corrective Action: None.

Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency Policy 17.6 Official Response Following a Resident Report – [VII] Agency Protection Against Retaliation
3. Interviews with the following:
    a. Assistant Chief Juvenile Probation Officer,
    b. Facility Director, and
    c. PREA Coordinator

Findings (By Subsection):

Subsection (a): Agency Policy 17.6 [VII-1] Agency Protection Against Retaliation states that the facility shall protect all residents and staff who report sexual abuse or sexual harassment or cooperates with an investigation from retaliation by other residents or staff. There were no residents who reported a sexual abuse. The agency policy also requires it to designate which staff members or departments are charged with monitoring retaliation. There have been zero (0) instances of alleged retaliations in the past 12 months.

Subsection (b): Agency Policy 17.6 [VII-2] Agency Protection Against Retaliation states that the facility employs

multiple protection measures such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abuser from contact with victims, and emotional support services for residents or staff that fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. The PREA is charged with monitoring for retaliation for reporting sexual abuse, sexual harassment or cooperating with investigations. Staff could articulate to the Auditor the ways they would uncover retaliation and monitor retaliation. Interviews with the Assistant Chief Juvenile Probation Officer and the PREA Coordinator corroborated these protection measures. There were no residents who reported a sexual abuse.

Subsection (c): Agency Policy 17.6 [VII-3] Agency Protection Against Retaliation requires the facility to continue monitoring for retaliation for at least 90 days following a report with a possible extension beyond 90 days if needed in compliance with this subsection. Facility policy also requires that the facility employ multiple protection measures such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abuser from contact with victims, and emotional support services for residents or staff that fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations. Interviews with the Assistant Chief Juvenile Probation Officer and the PREA Coordinator demonstrated that they were knowledgeable about the duty to monitor for retaliation for the time periods in this standard as well as required procedure.

Subsection (d): Agency Policy 17.6 [VII-4] Agency Protection Against Retaliation requires that for residents, such monitoring shall also include periodic status checks to be conducted by the Shift Supervisors. Status checks will be conducted randomly twice weekly and documented in the status checks binder in the supervisor's office. An interview with the PREA Coordinator demonstrated that he was knowledgeable about the duty to monitor for retaliation periodically.

Subsection (e): Agency Policy 17.6 [VII-5] Agency Protection Against Retaliation states that if any other individual who cooperates with an investigation expresses a fear of retaliation, the agency shall take appropriate measures protect that individual against retaliation.

Subsection (f): Agency Policy 17.6 [VII-6] Agency Protection Against Retaliation the obligation to monitor shall terminate if the investigation determines the allegation is unfounded. An interview with the Assistant Chief Juvenile Probation Officer indicated that the facility would take appropriate measures to protect an individual against retaliation.

Corrective Action: None.

Standard 115.368 Post-allegation protective custody

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

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency Policy 17.6 Official Response Following a Resident Report – Post-allegation Protective Custody

3. Interviews with the following:
    a. Facility Director
    b. Medical Staff
    c. Staff who Supervise Residents in Isolation

Findings (By Subsection):

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

Corrective Action: None.

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency policy 17.7 Investigations – Criminal Investigations
3. MOU with the Fort Bend County Juvenile Services Department and the Fort Bend County Sheriff's Department
4. Interviews with Interviews with the following:
    a. Investigative Staff
    b. Facility Director
    c. PREA Coordinator
    d. Fort Bend County Sheriff's Office Representative

Findings (By Subsection):

Subsection (a): Agency policy 17.7 [I] Criminal Investigations states that the Fort Bend County Sheriff's Department conducts criminal investigations into allegations of sexual abuse and sexual harassment and requires that requires these investigations to be conducted promptly, thoroughly and objectively for all allegations, including third party and anonymous reports. The facility policy requires these investigations to be conducted promptly, thoroughly and objectively for all allegations, including third party and anonymous reports. When sexual abuse is alleged, the FBCJPD's PREA Coordinator or investigators who have received special training in sexual abuse investigations involving juvenile victims shall conduct an investigation for only administrative purposes. In the past 12 months, the facility has conducted no administrative investigations and no referrals of sexual abuse (occurring in the facility) have been made to the Fort Bend

County Sheriff's Department for criminal investigations. The Auditor interviewed the PREA Coordinator who confirmed his knowledge of the requirements of this standard and all its subsection; he further acknowledged that investigations are conducted in accordance with these requirements. The Auditor communicated with the Fort Bend County Sheriff's criminal investigator who indicated that there had been no criminal investigations in the past year.

Subsection (b): Agency policy 17.7 [2] Criminal Investigations policy requires all facility investigators to have special training in sexual abuse investigations involving juvenile victims per Standard 115.334. The facility has two (2) individuals that have completed the PREA Resource Center Training for Trainers – Specialized Training: Investigating Sexual abuse in Correctional Settings conducted by The Moss Group, Inc. sponsored by the National PREA Resource Center. The Auditor was provided with Certificates of Attendance for the two (2) employees who earned certificates by attending three (3) day training. An interview with a facility investigator corroborates this training was completed. The PREA Coordinator confirmed he took this course and could articulate the key components of the course related to investigations in correctional settings and he confirmed that his investigations follow the requirements of this standard. The Auditor communicated with the Fort Bend County Sheriff's criminal investigator who indicated that he had received special training in sexual abuse investigations in juvenile confinement settings.

Subsection (c): Agency policy 17.7 [I] [3-F] Criminal Investigations policy requires the Fort Bend County Sheriff's investigators to gather and preserve evidence, interview appropriate persons and review prior complaints involving the alleged perpetrator as required by this subsection**.** Interviews with facility investigative staff demonstrate knowledge of how to gather and preserve direct and circumstantial evidence, available electronic monitoring information, interview specific victims, suspected perpetrators, witnesses and review prior reports of sexual abuse involving the suspected perpetrator.

Subsection (d): Agency policy 17.7 [IV-5] Criminal Investigations policy prohibits the facility from terminating an investigation solely because the source of the allegation recants the allegation. An interview with a facility investigator stated that the investigation would continue even if the reporter recanted the allegation.

Subsection (e): Agency policy 17.7 [I-6] The facility policy prohibits investigators from conducting compelled interviews in certain situations. The policy states "When the quality of evidence appears to support criminal prosecution, the facility shall conduct compelled interview only after consulting with prosecutors. An interview with a facility investigator stated that compelled interviews would be conducted after consulting with prosecutors.

Subsection (f): Agency policy 17.7 [I-7] Criminal Investigations requires investigators to assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the person's status as a resident or staff. The policy requires the investigation to proceed and a polygraph examination cannot be used as a condition for proceeding with the investigation. An interview with a facility investigator stated that a polygraph examination would not be used in an investigation.

Subsection (g): Agency policy 17.7 [IV-1] The facility requires administrative investigations to include an effort to determine whether staff actions or failures to act contributed to the abuse. Additionally, facility policy requires investigators to document the investigation in written reports that include descriptions of the evidence, the reasoning behind credibility assessments, and investigative facts and findings. An interview with a facility investigator stated that all investigations would make that determination.

Subsection (h): Agency policy 17.7 [IV-2]_The facility policy requires that investigations shall be documented per TJJD incident form requirements and investigation requirements including:

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

An interview with the investigative staff indicated that no criminal investigations had been conducted at this facility.

Subsection (i): Agency policy 17.7 [IV-3] Administrative Agency Investigations policy requires investigators to refer for prosecution substantiated allegations of conduct that appear to be criminal. There have zero (0) substantiated allegations of conduct that appeared to be criminal. An interview with the investigative staff indicated that conduct that appears to be criminal would be referred to the Fort Bend County Sheriff's Office.

Subsection (j): Agency policy 17.7 [IV-4] Administrative Agency Investigations policy requires that all written reports of administrative and criminal investigations shall be retained as long as the alleged abuser is incarcerated or employed by the agency plus five years, unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention.

Subsection (k): Agency policy 17.7 [IV-5] The facility policy states that the departure of the alleged abuser of victim from the employment or control of the facility shall not provide a basis for terminating an investigation. An interview with the investigative staff indicated that the policy would be followed without exception.

Subsection (l): Agency policy 17.7 [IV-6] The facility policy requires that any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements. Interviews with facility investigators confirmed that TJJD investigations follow the PREA standards.

Subsection (m): Agency policy 17.7 [IV-7] The facility policy requires the facility to cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation. Interviews with staff indicate that the facility maintains close contact with TJJD and Fort Bend County Sheriff's Department who conduct external investigations. There have been no investigations at this facility as confirmed by the facility investigator and by the Fort Bend County Sheriff's Department investigator.

Corrective Action: None.

Standard 115.372 Evidentiary standard for administrative investigations

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

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency Policy 17.7 Investigations [V] Evidentiary Standard for Administrative Investigations
3. Interview with the following:
    a. Investigative Staff

Findings (By Subsection):

Subsection (a): Agency Policy 17.7 [V] Evidentiary Standard for Administrative Investigations states that it will

impose no standard higher than a preponderance of evidence or a lower standard of proof for determining whether allegations of sexual abuse or sexual harassment are substantiated. The interview with the facility investigator confirmed his knowledge of the required standard of proof and that his practice was to use "preponderance of the evidence" in facility investigations.

Corrective Action: None.

Standard 115.373 Reporting to residents

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

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency Policy 17.7 Investigations [V] Reporting to Residents
3. Resident Allegation Notification Form
4. Interviews with the following:
    a. Executive Director/Chief Juvenile Probation Officer
    b. Investigative Staff

Findings (By Subsection):

Subsection (a): Agency Policy 17.7 [VI-1] Reporting to Residents policy requires that any resident who makes an allegation that he or she suffered sexual abuse in the facility shall be informed verbally or in writing, of all notifications, as to whether the allegation has been determined to be substantiated, unsubstantiated or unfounded following an investigation by the agency. Interviews with the Executive Director/Chief Juvenile Probation Officer and investigative staff confirmed this procedure. The PAQ documents that in the past 12 months, there were no criminal and/or administrative investigations conducted. The interview with the Executive Director/Chief Juvenile Probation Officer and facility investigator confirmed that the notifications required under this section would be provided as a part of all investigations.

Subsection (b): Agency Policy 17.7 [VI-2] Reporting to Residents policy requires that relevant information will be requested from external investigators if the facility did not conduct the investigation in order to notify the resident. The PAQ documented that there had been no external investigations conducted in the past 12 months by the Fort Bend County Sheriff's Department or TJJD on PREA related conduct.

Subsection (c): Agency Policy 17.7 [VI-3] Reporting to Residents requires notification of the resident when 1) the staff member is no longer posted within the resident's unit; 2) the staff member is no longer employed at the facility; the staff member has been indicted; or the staff member has been convicted on a charge related to sexual abuse within the facility.

Subsection (d): Agency Policy 17.7 [VI-4] Reporting to Residents policy requires the facility to provide notification to the resident (regarding abuse by another resident) when the abuser has been indicted or the

abuser has been convicted on a charge related to sexual abuse within the facility.

Subsection (e): Agency Policy 17.7 [VI-5] Reporting to Residents policy requires the facility to document all such notifications or attempted notifications under this standard.

Corrective Action: None.

Standard 115.376 Disciplinary sanctions for staff

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

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency Policy 17.8 Discipline[I]

Findings (By Subsection):

Subsection (a): Agency policy 17.8 [I-1] Disciplinary Sanctions for Staff provides that staffs that violate facility sexual abuse or sexual harassment policies are subject to disciplinary sanctions up to and including termination as required by this standard. In the past 12 months, the facility reports that no staff has violated the facility policy on sexual abuse or sexual harassment. No staff have been terminated, disciplined or resigned for PREA related conduct and no reports of staff misconduct/criminal behavior have been made to law enforcement.

Subsection (b): Agency policy 17.8 [I-1] provides that the facility shall terminate staff members found to have engaged in sexual abuse.

Subsection (c): Agency policy 17.8 [I-2] Disciplinary Sanctions for Staff requires disciplinary sanctions to be commensurate with the nature and circumstances of the acts committee, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories.

Subsection (d): Agency policy 17.8 [I-3] Disciplinary Sanctions for Staff requires the facility to report all terminations for violations of policy on sexual abuse or sexual harassment, or resignations by staff that would have been terminated, if not for their resignation to TJJD and the Fort Bend County Sheriff's Department, unless the activity was clearly not criminal.

Standard 115.377 Corrective action for contractors and volunteers

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency Policy 17.8 Discipline (II)(1) Corrective Action for Contractors and Volunteers
3. Interviews with the following:
    a. Detention Center Director

Findings (By Subsection):

Subsection (a): Agency Policy 17.8 [II-1] Corrective action for Contractors and Volunteers policy states that the facility shall prohibit any contractor or volunteer, who engages in sexual abuse, from contact with residents and shall report to TJJD, local law enforcement agencies (unless not criminal conduct) and to relevant licensing bodies as required by this standard. In the past 12 months, the Facility reports that no contractors or volunteers have been reported to law enforcement for engaging in sexual abuse of residents. The interview with the Detention Center Director confirmed their knowledge of this requirement and indicated this would be the practice in the event such a situation occurs.

Subsection (b): Agency Policy 17.8 [II-1] Corrective action for Contractors and Volunteers policy requires the facility to take appropriate remedial measures against a volunteer or contractor who violates the facility sexual abuse or sexual harassment policies. Interview with the Detention Center Director corroborated the information submitted in the PAQ. Contact with residents will be prohibited.

Corrective Action: None.

Standard 115.378 Disciplinary sanctions for residents

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

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency Policy 17.8 [II-1] Discipline – [III] Interventions and Disciplinary Sanctions for Residents
3. Interviews with the following:
    a. Facility Administration
    b. Medical Staff

Findings (By Subsection):

Subsection (a): Agency Policy 17.8 Discipline – [III-1] Interventions and Disciplinary Sanctions for Residents provides that a resident may be disciplined after a substantiated finding in an administrative investigation or a criminal finding that a resident participated in the sexual abuse of another resident or staff in compliance with this standard. The PAQ documents that there have been no administrative or criminal findings regarding resident on resident sexual abuse that have occurred in the facility in the past 12 months. Interviews with Facility Administrators confirm their knowledge of the requirements of this standard related to resident discipline and acknowledge that practice would be followed in such an event.

Subsection (b): Agency Policy 17.8 Discipline – [III-2] Interventions and Disciplinary Sanctions for Residents requires any disciplinary sanctions for residents to consider the nature and circumstances of the abuse, the resident's disciplinary history, the sanctions imposed for comparable offenses by other residents with similar histories, and whether a resident' mental disabilities or mental illness contributed to his or her behavior. The policy requires that if isolation is used, the resident must be provided certain protections (i.e., educational programming, large-muscle exercise, medical/mental health visits) as detailed by this subsection which are all contained in the policy.

Subsection (c): Agency Policy 17.8 Discipline – [III-3] Interventions and Disciplinary Sanctions for Residents requires the discipline process to consider whether a resident's mental disabilities or mental illness contributed to his or her behavior. The interview with the Facility Administration indicated this is the procedure.

Subsection (d): Agency Policy 17.8 Discipline – [III-4] Interventions and Disciplinary Sanctions for Residents provides that the facility offers therapy and counseling for the resident. Participation in therapy of counselling is not required to access general programming or education services. An interview with the medical staff confirmed that residents would be provided therapy and counseling and be provided access to all programs and education.

Subsection (e): Agency Policy 17.8 Discipline – [III-5] Interventions and Disciplinary Sanctions for Residents prohibits the facility from disciplining a resident for sexual contact with staff unless the staff member did not consent to such contact.

Subsection (f): Agency Policy 17.8 Discipline – [III-6] Interventions and Disciplinary Sanctions for Residents provides that a report of sexual abuse made in good faith shall not constitute a false report for disciplinary purposes.

Subsection (g): Agency Policy 17.8 Discipline – [III-7] Interventions and Disciplinary Sanctions for Residents prohibits all sexual activity between residents and disciplines residents.

Corrective Action: None.

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

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

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

information on specific corrective actions taken by the facility.

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency policy 17.9 Medical and Mental Care
3. Fort Bend County Juvenile Detention Center Intake Screening for Potential Sexual Aggressive Behavior and/or Sexual Victimization form
4. Interviews with the following:
   a. Residents who Disclose Sexual Victimization at Risk Screening
   b. Staff Responsible for Risk Screening
   c. Medical/mental health secondary materials

Findings (By Subsection):

Subsection (a): Agency policy 17.9 [I-1] Medical and Mental Health Screenings; History of Sexual Abuse requires the facility to offer a resident that has experienced prior sexual victimization a follow-up meeting with medical or mental health practitioners within 14 days of the intake screening. In the past year, there were no residents who disclosed prior sexual victimization, whether it occurred in an institutional setting or in the community. Resident and staff interviews indicate follow-up medical and mental health care (counseling) is offered should residents wish to talk about their victimization with their counselors. The Auditor observed mental health secondary materials to demonstrate the residents were offered services and referred to appropriate services in the community. Interviews with staff who conduct the screening indicate that these follow-up services are provided.

Subsection (b): Agency policy 17.9 [I-2] Medical and Mental Health Screenings; History of Sexual Abuse policy requires the facility to offer a resident that has previously perpetrated sexual abuse a follow-up meeting with medical or mental health practitioners within 14 days of the intake screening. There were no residents who disclosed previous sexual abuse perpetration. Interviews with staff who conduct the screening indicate that these follow-up services are provided.

Subsection (c): Agency policy 17.9 [I-3] Medical and Mental Health Screenings; History of Sexual Abuse requires staff to keep information related to sexual victimization or abusiveness confidential. Resident information in the TJJD JCMS system is confidential through role-based security.

Subsection (d): Agency policy 17.9 [I-4] Medical and Mental Health Screenings; History of Sexual Medical requires mental health practitioners to 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. Interviews with mental health staff indicate that informed consent is obtained.

Corrective Action: None.

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the Auditor's analysis and reasoning, and the Auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency policy 17.9 Medical and Mental Care [II] Access to Emergency Medical and Mental Health Care
3. Memorandum of Understanding (MOU) with Harris Hospital System
4. Interviews with the following:
    a. Medical staff
    b. Residents who Reported a Sexual Abuse
    c. First Responders

Findings (By Subsection):

Subsection (a): Agency policy 17.9 [II-1] Access to Emergency Medical and Mental Health Care provides that resident victims of sexual abuse shall receive timely unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgement. Interviews with medical and mental health staff confirm this is the practice. Emergency medical and mental health care services are provided through a Memorandum of Understanding (MOU) between the facility and Harris Health System. An interview with the medical staff stated that residents would be taken to a Harris Health System hospital.

Subsection (b): Agency policy 17.9 [II-2] Access to Emergency Medical and Mental Health Care provides if no qualified medical or mental health practitioners are on duty at the time of a report of recent abuse is made, the first responder shall take preliminary steps to protect the victim pursuant to PREA standard 115.362 and shall immediately notify the appropriate medical and mental health practitioners. The facility PAQ documents that there have been no allegations of sexual abuse in the previous 12 months that would require emergency medical treatment or crisis intervention services. Interviews with first responders and medical staff could state the first responder protocols.

Subsection (c): Agency policy 17.9 [II-3] Access to Emergency Medical and Mental Health Care requires the facility to offer resident victims of sexual abuse timely information about and timely access to emergency contraception and sexually transmitted infection prophylaxis, in accordance with professional accepted standards of care, and where medically appropriate. Interviews with medical staff confirm that this would occur at the Harris Health System hospital where the resident would be transported for the SANE/SAFE examination.

Subsection (d): Agency policy 17.9 [II-4] Access to Emergency Medical and Mental Health Care provides that it shall offer these treatment services (under this standard) to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Interviews corroborate that victims are not charged for these treatment services. The Memorandum of Understanding (MOU) with Harris Hospital System documents this arrangement.

Corrective Action: None.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ
2. Agency policy 17.9 Medical and Mental Care [III] Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers
3. Memorandum of Understanding (MOU) with Harris Hospital System
4. Memorandum of Understanding (MOU) with Fort Bend County Women's Center
5. Interviews with the following:
    a. Medical and Mental Health staff
    b. There were no residents who Reported a Sexual Abuse or who required ongoing medical and/or mental health care for sexual abuse victims and abusers

Findings (By Subsection):

Subsection (a): Agency policy 17.9 [III-1] Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers policy provides that the facility shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who are victims of have been victimized by sexual abuse in prison, jail, lockup, or juvenile facility. Interviews with medical and mental health staff indicate this is the practice and that the requirements of this standard are met with policy and the actual practice would be compliant with this standard if an incident of sexual abuse occurred in the facility.

Subsection (b): Agency policy 17.9 [III-2] Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers provides the evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. An interview with the facility medical staff indicated that victims would be provided follow-up services, treatment plans and possible referrals for continued care after their release.

Subsection (c): Agency policy 17.9 [III-3] Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers provides that the facility shall provide such victims with medical and mental health services consistent with the community level of care. An interview with the facility medical staff indicated that victims would be provided services consistent with the community level of care.

Subsection (d): Agency policy 17.9 [III-4] Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers provides that the facility shall offer pregnancy tests to resident victims of sexually abusive vaginal penetration that occurs while they are resident of any facility.

Subsection (e): Agency policy 17.9 [III-5] Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers provides that if pregnancy results from a sexual assault, resident victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services. An interview with the facility medical staff indicated that if a victim became pregnant, she would be provided all services noted in the standard.

Subsection (f): Agency policy 17.9 [III-6] Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers requires that tests for sexually transmitted infections, as medically appropriate, will be offered to resident victims of sexual abuse that occurs while they are residents of any facility.

Subsection (g): Agency policy 17.9 [III-7] Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers requires it to provide all treatment services to the victim without financial cost as noted in the MOU and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

Subsection (h): Agency policy 17.9 [III-8] Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers policy requires an attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and shall offer treatment when deemed appropriate by mental health. An interview with the facility medical staff indicated that a mental health evaluation would be offered.

Corrective Action: None.

Standard 115.386 Sexual abuse incident reviews

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

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency Policy 17.10 Data Collection and Reviews [I] Sexual Abuse Incident Reviews
3. Interviews with the following:
    a. Executive Director/Chief Juvenile Probation Officer
    b. PREA Coordinator
    c. Incident Review Team Member

Findings (By Subsection):

Subsection (a): Agency Policy 17.10 Data Collection and Reviews [I-1] Sexual Abuse Incident Reviews requires a sexual abuse incident review to be conducted at the conclusion of every sexual abuse investigation, including incidents where there was not enough evidence to substantiate the allegation, unless the investigation shows the allegation is unfounded. The facility reports that in the past 12 months, there have been zero (0) sexual abuse investigations; thus, there have been no sexual abuse incident reviews yet conducted.

Subsection (b): Agency Policy 17.10 Data Collection and Reviews [I-2] Sexual Abuse Incident Reviews requires the review to ordinary occur within 30 days of the conclusion of the investigation.

Subsection (c): Agency Policy 17.10 Data Collection and Reviews [-3I] Sexual Abuse Incident Reviews provides that the review team shall include upper- level management officials; Chief Probation Officer, Administrative Designee, PREA Coordinator, Facility Administrator and Assistant Facility Administrator with input from line supervisors, investigators and medical or mental health practitioners.

Subsection (d): Agency Policy 17.10 Data Collection and Reviews [I-4] Sexual Abuse Incident Reviews requires that the review team shall consider:

(a) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;

(b) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or, gang affiliation; or was motivated or otherwise caused by other group dynamic at the facility;

(c) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse (camera placement, blind spots, training curriculum, and program);

(d) Assess the adequacy of the staffing levels in that area during different shifts;

(e) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and

(f) Prepare a report of its findings, including but not limited to determination made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submit such report to the Chief Probation Officer, Facility Administrator and PREA Coordinator. Interviews with facility staff indicate the considerations in this subsection would be a part of the team review.

Interviews with Interviews with Executive Director/Chief Juvenile Probation Officer, PREA Coordinator and Incident Team members indicate their knowledge and understanding of the sexual abuse incident review process as required.

Subsection (e): Agency Policy 17.10 Data Collection and Reviews [I-4] [G] Sexual Abuse Incident Reviews requires that the facility administrator shall implement the recommendations for improvement, or shall document the reasons for not doing so.

Corrective Action: None.

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency Policy 17.10 Data Collection and Review – [II] Data Collection
3. PREA Annual Data Review and Corrective Action Plan dated May 17, 2017 for 2016 and 2017
4. Fort Bend County Juvenile Services PREA Data Collection May 23, 2017
5. FORT BEND COUNTY website: http://FortBendcountytx.gov/DocumentCenter/View/2015

Findings (By Subsection):

Subsection (a) and (c): Agency Policy 17.10 [II] Data Collection [II] [1 and 3] provides that it shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The data shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice (DOJ). The Auditor reviewed the data collection and aggregate report and determined compliance with this section.

Subsection (b): Agency Policy 17.10 [II-2] Data Collection requires the agency to aggregate the incident-based sexual abuse data at least annually.

Subsection (d): Agency Policy 17.10 [II-4] Data Collection requires the facility to maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

Subsection (e): Agency Policy 17.10 [II-5] Data Collection requires the facility to obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents.

Subsection (f): Agency Policy 17.10 [II-6] Data Collection requires the facility, upon request, to provide all such data from the previous calendar year to the DOJ no later than June 30. The agency recently submitted the Survey of Sexual Victimization, 2016 to the US Department of Justice.

Corrective Action: None.

Standard 115.388 Data review for corrective action

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

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency Policy 17.10 Data Collection and Review [III] Data Review for Corrective Action
3. Agency's website posting of 2014 PREA Annual Survey of Sexual Violence submitted in 2015 http://www.fortbendcountytx.gov/modules/showdocument.aspx?documentid=37842
4. Fort Bend County Detention Center PREA Data Collection (2014 – 2016)
5. Interviews with the following:
    a. Executive Director/Chief Juvenile Probation Officer
    b. PREA Compliance Coordinator

Findings (By Subsection):

Subsection (a): Agency Policy 17.10 [III-1] Data Review for Corrective Action requires the facility to review data collected and aggregated under Standard 115.387 annually to assess and improve the effectiveness of sexual abuse prevention, detection, and response policies, practices, and training including: 1) identifying problem areas; 2) taking corrective action on an ongoing basis; and 3) preparing an annual report for each facility and the

department as a whole. Interviews with Facility administration indicate this process is in place as required by this standard. Interviews with Executive Director/Chief Juvenile Probation Officer and PREA Compliance Coordinator indicate their knowledge of the data review required by this section and they articulated appropriately and effectively how they will use this process to improve their overall PREA compliance and the sexual safety of the facility.

Subsection (b): Agency Policy 17.10 [III-2] Data Review for Corrective Action requires the report to include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the facility's progress in addressing sexual abuse. The Auditor reviewed the facility's PREA Data Collection which documents data comparisons from 2012-2016.

Subsection (c): Agency Policy 17.10 [III-3] Data Review for Corrective Action requires the Chief Juvenile Probation Officer to approve the report and make it readily available to the public through the Fort Bend County website. The Auditor verified the data and report approved by the Chief Juvenile Probation Officer are posted on the facility website.

Subsection (d): Agency Policy 17.10 [III-4] Data Review for Corrective Action states that the department will redact any specific information from the reports when publication of such information would present a clear and specific threat to the safety and security of the facility. The Fort Bend County Juvenile Services Department shall indicate the nature of the material redacted (when applicable). The agency has not redacted any information from the report that would present a clear and specific threat to the safety and security of the facility which the interview with the PREA Coordinator confirmed.

Corrective Action: **None.**

Standard 115.389 Data storage, publication, and destruction

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

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

Evidence Reviewed (documents, interviews, site review):

1. Completed Pre-Audit Questionnaire (PAQ)
2. Agency Policy 17.10 Data Collection and Review – [IV] Data Storage and Publication, and Destruction
3. PREA Annual Data Review and Corrective Action Plan dated May 17, 2017
4. FORT BEND COUNTY website: **http://www.fortbendcountytx.gov/modules/showdocument.aspx?documentid=37355**
5. Interview with the following:
    a. PREA Coordinator

Findings (By Subsection):

Subsection (a): Agency Policy 17.10 [IV-1] Data Storage and Publication, and Destruction requires the agency to ensure that all data collected pursuant to Standard 115.387 are securely retained. The PREA Coordinator

confirmed compliance with this standard.

Subsection (b): Agency Policy 17.10 [IV-2] Data Storage and Publication, and Destruction requires the agency to make all aggregated sexual abuse data from facilities under its direct control, and private facilities with which it contracts, readily available to the public through the Fort Bend County website on an annual basis. The Auditor reviewed the data on the website to determine compliance for this subsection.

Subsection (c): Agency Policy 17.10 [IV-3] Data Storage and Publication, and Destruction require the agency to remove all personal identifiers prior to making aggregated sexual abuse data publicly available. The Auditor reviewed the aggregated data and no personal identifiers were present.

Subsection (d): Agency Policy 17.10 [IV-4] Data Storage and Publication, and Destruction requires the agency that unless Federal, State or local laws requires, the department shall maintain all abuse data collected pursuant to PREA Standard 115.387 for at least 10 years after the date of its initial collection.

Corrective Action: None.

AUDITOR CERTIFICATION

I certify that:

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

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

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

Glen E. McKenzie, Jr. *July 7, 2017*

Auditor Signature Date