# PREA AUDIT REPORT

**☐ INTERIM ☒ FINAL**

**JUVENILE FACILITIES**

Date of report: February 10, 2017

## Auditor Information

<table>
<thead>
<tr>
<th>Auditor name: La Cole Archuletta</th>
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<tbody>
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Date of facility visit: July 11-12, 2016

## Facility Information

<table>
<thead>
<tr>
<th>Facility name: Albuquerque Boys Reintegration Center (ABRC)</th>
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<tbody>
<tr>
<td>Facility physical address: 4000 Edith Blvd., NE, Albuquerque, New Mexico 87107</td>
</tr>
<tr>
<td>Facility mailing address: (if different from above) Click here to enter text.</td>
</tr>
<tr>
<td>Facility telephone number: 505-841-4253</td>
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The facility is:  
- ☒ State  
- ☐ County  
- ☐ Military  
- ☐ Municipal  
- ☐ Private for profit  
- ☐ Private not for profit

Facility type:  
- ☒ Correctional  
- ☐ Detention  
- ☐ Other

Name of facility’s Chief Executive Officer: Tamera Marcantel

Number of staff assigned to the facility in the last 12 months: 18

Designed facility capacity: 12

Current population of facility: 11

Facility security levels/inmate custody levels: Low

Age range of the population: 16-21

## Name of PREA Compliance Manager: Steven Cox  
Title: Program Supervisor  
Email address: StevenM.Cox@state.nm.us  
Telephone number: 505-841-2486

## Agency Information

<table>
<thead>
<tr>
<th>Name of agency: Juvenile Justice Services</th>
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<tbody>
<tr>
<td>Governing authority or parent agency: (if applicable) Children, Youth &amp; Families Department</td>
</tr>
<tr>
<td>Physical address: 1120 Paseo De Peralta, Santa Fe, New Mexico 87501</td>
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<tr>
<td>Mailing address: (if different from above) P.O Box Drawer 5160, Santa Fe, New Mexico 87501</td>
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<td>Telephone number: 505-827-7629</td>
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## Agency Chief Executive Officer

| Name: Tamera Marcantel  
| Email address: Tamera.Marcantel@state.nm.us  
| Telephone number: 505-216-8593 |
| Title: Director, Juvenile Justice Services |

## Agency-Wide PREA Coordinator

| Name: Eugene Brewster  
| Email address: Eugene.Brewster@state.nm.us  
| Telephone number: 505-252-8020 |
| Title: PREA Coordinator |
AUDIT FINDINGS

Narrative:
Six weeks in advance of the audit, posters announcing the upcoming review were placed throughout the facility, including at the entrance of the facility as well as in the living unit. The posters explained the purpose of the audit and provided residents, staff and visitors with the auditor’s contact information. Photos were sent to the auditor showing that they were in place. In addition, audit postings were observed throughout the facility during the site visit and no letters were received from residents or staff prior to the site visit.

Within eighteen days before the on-site visit, the Pre-Audit Questionnaire (PAQ) and supporting documents were received. The auditor reviewed the documents using the PREA audit compliance tool. Prior to the visit, the auditor also reviewed the PAQ, agency and facility policies, procedures and supporting documentation. The auditor contacted national and local rape crisis advocates to determine if they received any reports from the Albuquerque Boys Reintegration Center (ABRC). The national rape crisis organization responded, but the agency at the local level did not.

On July 11, 2016, an introduction meeting was held. The following staff members were in attendance:

Adam Cordova, Juvenile Reintegration Center Superintendent
Felix Chavez, Program Manager
Steven Cox, PREA Compliance Manager/Program Supervisor
Greg Nelson, Performance/Policy Bureau Chief
Valerie Valverde, PREA Administrative Support
Patricia Baca, PREA Management Analyst
Eugene Brewster, PREA Coordinator
La Cole Archuleta, PREA Auditor

After introductions, the auditor toured the facility, the housing unit and each room, shower and restrooms, staff offices, camera room, records and staff locker area, food services, the day hall area and outside/recreation area. The auditor also reviewed the locations where medication is dispensed, where camera monitoring is done and where resident files are kept.

The auditor interviewed key agency and facility staff, as well as residents and specialized staff. PREA audit interview protocol questions were used during all interviews. Prior to the on-site visit, Mrs. Marcantel was contacted to see if there was new or additional information since her last interview in May 2016.

Specialized staff interviews were conducted on-site on July 11-12, 2016. These interviews included the contracts administrator for private prison contract monitoring (PREA Coordinator), facility investigator (grievance officer) for resident-on-resident investigations, and the Office of the Inspector General investigator who conducts staff-on-resident investigations. The interviews with the facility level Human Resources director and manager and volunteer were done by phone during the visit.

Two interviews, with one of the youth corrections staff and nurse were conducted on July 14, 2016 at the Albuquerque Girls Reintegration Center. These staff were not at the facility on July 11 or 12.

The auditor randomly selected eight residents to interview and included at least one resident from each room. Specialized interviews were conducted with residents who identified as being gay. At the time of the audit, there weren’t any residents who identified as transgender, intersex, disabled or limited English proficient, disclosed sexual victimization during risk screening, or reported sexual abuse.

There were seven completed resident interviews conducted while on site and one resident did not want to be interviewed.

One new resident was admitted during the last day of the on-site audit. The auditor sat in on the resident’s orientation.

ABRC staff stated that there were no residents that have been placed in segregated housing for risk of sexual victimization or who have alleged to have suffered sexual abuse. ABRC does not have segregated housing.

Additional informal interviews were conducted at various times during the audit.

Staff interviews included 11 random staff from security and non-security. Security staff from all three shifts were interviewed (day, swing and graveyard). Specialized staff interviews were conducted with the program manager for the superintendent, PREA compliance manager, PREA coordinator, intermediate or higher level facility staff, medical staff, mental health staff, staff members who perform screening for risk of victimization and abusiveness, intake staff, volunteer, staff assigned to the incident review team, designated employees charged with monitoring for retaliation and investigative staff. The auditor was
informed that there were no cross-gender strip or visual searches conducted or sexual abuse/sexual harassment allegations. There are no contractors at the facility.

ABRC has a small number of employees. There are two high level staff, the Program Manager and PREA Compliance Manager who were interviewed for several of the specialized staff interview questions.

The individual who answers the JJS Protective Service Reporting Line (Protective Services Screener) was interviewed after the on-site audit.

The auditor conducted a total of 32 staff interviews.

Mrs. Marcantel, the head of the agency, met with the auditor at ABRC.

The auditor found that both staff and residents were aware of the Prison Rape Elimination Act (PREA) standards, agency policy and facility procedures.

After the on-site audit, the facility personnel and PREA administration worked diligently to work on the corrective actions. The auditor and agency created a corrective action plan which the facility staff members and PREA administration completed. ABRC is now compliant with the PREA standards.
FACILITY CHARACTERISTICS:

Juvenile Justice Services (JJS) adopted the “Cambiar New Mexico” model, a program that shifts the focus from confinement and punishment to rehabilitation and regionalization. JJS continues to hold young people accountable while providing for their rehabilitation and preparing them for adulthood. Major initiatives include:

- Developing smaller reintegration centers across the state
- Creating smaller, safer and more nurturing living units/groups (therapeutic communities)
- Implementing youth-centered unit management and milieu therapy
- Developing individualized service plans addressing carefully assessed needs, strengths and risks
- Staffing of facilities with Youth Care Specialists (YCS) who receive training that provides security and therapeutic skill sets
- Providing rich programming, including education, vocational, behavioral health, medical and other services

The mission for Albuquerque Boys Reintegration Center is dedicated to improving the quality of life for the children in custody there. The Superintendent is Adam Cordova and the Program manager is Felix Chavez. The PREA Compliance Manager is Steven Cox.

ABRC has a capacity of 12 residents. The facility houses male residents age 16 to 21. The average length of stay at ABRC is three months. At the time of the visit, there were 11 residents. On the last day of the on-site audit, ABRC received a new resident.

ABRC is a low-secure level facility and serves as a reintegration center. There are six rooms that accommodate as many as three residents each. However, the facility cannot hold more than twelve residents. There are two shower and toilet areas on each side of the hallway. The facility provides access and transportation for residents for employment and community service, as well as education programs for residents. The facility develops resources and programs in the community to assist the residents to successfully transition back into the community.

ABRC does not have on-site clinical staff. Residents are referred to the local hospital for medical treatment. However, residents are provided medication that is dispensed and monitored by nurses employed by Children, Youth & Families Department (CYFD).

There are 18 staff members and 15 volunteers at ABRC. There are no contractors.
SUMMARY OF AUDIT FINDINGS:

The auditor observed that commendable efforts were made towards becoming compliant with PREA standards. It was evident that the facility had proactively worked to implement the PREA standards into the facility and create a culture that enforces zero tolerance for sexual abuse and sexual harassment. ABRC made physical changes to the facility, such as removal of doors and implementation of processes that reduced blind spots. ABRC plans to make additional improvements in this area such as removing blinds, adding windows to doors and convex mirrors in offices or where staff and residents may be isolated, and by ensuring certain doors are kept locked. During the audit, the auditor requested that the resident file cabinets be moved to an area with limited staff access. The locked file cabinets were moved to a room with limited access. Only those who need access to the files have a key. The file cabinets also have a label identifying them as confidential.

During the past 12 months, ABRC reported that no allegations of sexual abuse or sexual harassment were received. Therefore, there were zero administrative and criminal investigations related to sexual abuse or sexual harassment conducted at ABRC.

Overall, the interviews of residents indicated that they were aware of and understood the agency’s zero tolerance policy. At intake, residents receive written materials, including a client handbook and PREA brochure that provides detailed information about the agency’s zero tolerance policy, multiple ways to report sexual abuse or sexual harassment. Residents also watch a video entitled “Sexual Misconduct Youth Education Video” within ten days of intake. Residents indicated that they understand the different ways to report sexual abuse and pointed out that there are posters throughout the facility that list multiple ways to report sexual misconduct.

Facility staff who were interviewed indicated that they received PREA training. Training records confirm this. Staff members were aware of the multiple ways residents can report sexual abuse or sexual harassment. Staff are aware of their responsibilities to report sexual abuse.

After reviewing documents and conducting interviews with residents and staff, the auditor found that the agency and facility have made PREA compliance a high priority. Staff has received training and offenders are educated on the agency’s PREA policies. Additionally, staff have devoted time to updating policies to ensure compliance with the PREA standards. Interviews with agency leaders and facility management staff reinforced the goal that the agency is committed to implementing the PREA standards as well as protecting residents from sexual abuse.

An interim compliance report reflected that there were eleven standards that were non-compliant at ABRC. A required corrective action period not to exceed 180 days began August 13, 2016. The auditor worked with the PREA Coordinator, facility administration and facility staff to develop corrective action plan. The auditor reviewed documentation to determine compliance. ABRC completed their required corrective actions requires to bring the facility into compliance with the PREA standards. ABRC has demonstrated that it has achieved full compliance with the PREA standards as of the date of this final report.

An explanation of the findings related to each standard is provided in this report.

Number of standards exceeded: 0
Number of standards met: 41
Number of standards not met: 0
Non-applicable: 0
Standard 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

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

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

Children, Youth & Families Department (CYFD) Juvenile Justice Services (JJS) provided Policy 5.24 A PREA Compliance – Employee Preparedness section 1.2 as verification that the agency is committed to providing a safe and secure environment, free from all forms of sexual misconduct and retaliation for clients and employees. To that end, JJS has zero tolerance for sexual misconduct and maintains procedures regarding prevention, detention and response to such conduct. 1.1 states that the purpose of the procedure is to prevent, detect and respond to all allegations of sexual misconduct – including sexual abuse and harassment. The agency uses sexual misconduct as an umbrella term to include sexual abuse, sexual assault and sexual harassment.

During the on-site visit to Albuquerque Boys Reintegration Center (ABRC), it was observed by this auditor that staff were aware of the agency’s zero tolerance policy towards sexual abuse and sexual harassment and were familiar with the agency’s PREA policy.

The policy states that sexual misconduct is an “umbrella term” that defines all incidents of sexual abuse and sexual harassment. Examples of sexual misconduct are listed in the policy. Sexual abuse, sexual assault and sexual harassment are mentioned in policy, but are not defined. PREA standards define sexual abuse, including voyeurism by a staff member, contractor or volunteer and sexual harassment. The auditor was provided updated policies on July 12, 2016 as evidence that corrections were made. PREA standard definitions of sexual abuse and sexual harassment were added to Policy 5.24 A, Policy 5.24 B and Policy 5.24 C defines sexual misconduct as the umbrella term and added definitions for sexual abuse of a client by an employee, contractor, volunteer or student intern, voyeurism of an employee, contractor, volunteer or student intern, sexual harassment of a client by another client and sexual harassment of a client by an employee, contractor, volunteer or student intern.

Additional changes were made to the stand alone policy 03, Directives 16-001, 16-002, 16-004 and 16-005. The specific changes will be explained as they apply in the applicable standard within this audit report. The agency recognizes the urgency of compliance with the PREA standards and understands the importance of having accurate policies. Therefore, these policies and Directives will be effective on September 1, 2016. After being reviewed and approved by the auditor, the policies were updated on July 25, 2016 by Policy & Procedure Manager.

Once the policies and directives are issued, they will be posted on the agency website. The superintendents, deputy directors, Office of the Inspector General, and training academy will begin on-site training of employees, contractors, volunteers and student interns to make them aware of the changes. The Policy & Procedure Manager will provide written documentation from the PREA compliance managers for the facilities that have received a PREA audit verifying when their employees, contractor, volunteers and student interns have been trained on the changes.

Required Corrective Action:
Provide documentation that the following policies were implemented and that staff at the facility have been trained in these updates. Policy 5.24 A, Policy 5.24 B, Policy 5.24 C, Directive 16-001, 16-002, 16-004 and 16.005.

Verification of Corrective Action since the Audit:
The auditor was provided with updated policies on July 12, 2016 as evidence and demonstration that the policies were updated. On October 11, 2016, the PREA Coordinator provided documentation that ABRC employees received training on the policies and updated directive.
The definitions from the PREA standards for sexual abuse and sexual harassment were added to Policy 5.24 A, Policy 5.24 B and Policy 5.24 C. Sexual misconduct is the “umbrella term” and definitions were added for sexual abuse of a client by an employee, contractor, volunteer or student intern, voyeurism of an employee, contractor, volunteer or student intern, sexual harassment of a client by another client and sexual harassment of a client by an employee, contractor, volunteer or student intern. This was required so that the definition of sexual misconduct matches the definition of sexual abuse and sexual harassment in the standard.

Additional changes were made to the Stand alone policy 03, Directives 16-001, 16-002, 16-004 and 16-005. The policies and directives were issued on August 15, 2016 and effective September 1, 2016.

On October 20, 2016, the PREA Coordinator provided documentation that employees, contractors, volunteers and student interns received training on policy and directive changes.

The agency has designated an upper-level agency statewide PREA Coordinator. He reports to the Performance/Policy Bureau Chief. The Performance/Policy Bureau Chief reports to the Juvenile Justice Services Director. During the interview, he stated he has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities in the Child Youth and Family Department (CYFD) Juvenile Justice Services.

An organizational chart was provided to the auditor. The chart confirms that he reports to the Performance/Policy Bureau Chief. A job description that outlines the PREA Coordinator duties that lists his authority and responsibilities was provided.

Interviews with the agency head and the PREA Coordinator reinforced compliance with this standard.

ABRC has a designated PREA compliance manager. During interviews, the PREA compliance manager said he has sufficient time and authority to coordinate the facility’s efforts to comply with the PREA standards at ABRC. The PREA compliance manager is the youth corrections supervisor at ABRC and reports to the ABRC Manager.

An organizational chart confirms that this position reports to the manager of ABRC.

Policy, Materials, Interviews and Other Evidence Reviewed
Policy 5.24 A, PREA Compliance – Employee Preparedness
Policy 5.24 B, PREA Compliance – Client Education and Advocacy
Policy 5.24 C, PREA Compliance – Responding to Allegations
Pre-Audit Questionnaire completed by ABRC
Agency and ABRC Organization Chart
PREA Coordinator Job Duties
Memorandum from Director assigning for job duties to Deputy Superintendent/Manager
Interview with PREA Coordinator
Interview with PREA compliance manager
Updated Policies
Interview with Policy & Procedure Manager

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.

CYFD reports that it has a contract with the San Juan County Juvenile Detention Center for confinement of residents that meets the requirement of this standard. The auditor reviewed the contract and found that it met the requirements and includes PREA language to ensure the contracting entity’s obligation to adopt and comply with the
PREA standards. The contracting entity’s PREA Coordinator was on-site and attended the tour. He said that it is their intent to undergo a PREA audit.

The contract outlines the agency’s responsibility to monitor the contractor’s facility and operations to ensure compliance with the standard by conducting site visits and document reviews.

An interview with the contract administrator indicated the agency has the information within the contract.

An interview with the PREA Coordinator and contract administrator confirmed that it is the agency’s intent to have the PREA Coordinator work with the contracting entity and conduct on-site visits and monitoring. The PREA Coordinator and Performance/Policy Bureau Chief said that they plan to conduct a mock PREA audit to determine if the facility is on its way toward compliance with the PREA standards. As part of the contract monitoring, the PREA Coordinator needs to document that the contract agency is working toward PREA compliance. And since the facility has not had a PREA audit, verification that the facility is working on becoming compliant should be provided.

**Required Corrective Action:**
1. Provide documentation that the facility is being monitored by the PREA Coordinator.
2. Provide documentation that the facility is moving toward compliance and that they will have a PREA audit in the near future.

**Verification of Corrective Action:**
On September 29, 2016, the PREA Coordinator provided documentation that the contract facility is working towards compliance with the PREA standards. Additionally, the PREA Coordinator provided verification that he is monitoring the progress.

Policy, Materials, Interviews and Other Evidence Reviewed
Agency contract with San Juan County Juvenile Detention Center
Pre-audit Questionnaire completed by ABRC
Interviews with Maria Sanchez, Contract Administrator and Eugene Brewster, PREA Coordinator
Memo from PREA Coordinator Eugene Brewster
Interview with Greg Nelson, Performance/Policy Bureau Chief
PREA Coordinator report

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)

**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.**

Staffing Plan
A staffing plan for Albuquerque Boys Reintegration Center was provided and reviewed by the auditor. It did not meet the required elements in section (a). The plan did not include how each of the eleven elements are considered. However, on August 9, 2016, an updated staffing plan was provided. It includes all of the 11 elements required in the standard.

The staffing plan confirmed that the ABRC considers, but is not limited to, providing direct supervision ratios of 1:8 during the day and 1:12 at night in each living unit as well as installing security cameras to reduce blind spots. The superintendent, PREA compliance manager and PREA Coordinator regularly meet to discuss and approve the meeting minutes of the staffing plan.

In interviews with the PREA Coordinator it was confirmed that other staff such as behavioral health or classification staff can also attend the meetings. To date, ABRC has conducted one PREA staffing plan meeting.
The staffing plan included a vulnerability assessment that identified blind spots or areas where staff and residents might be isolated. During the on-site visits these areas were evaluated and facility and agency level staff identified plans to add windows in doors and convex mirrors in rooms or other places where staff and residents might be isolated. It was also determined that in some areas blinds would be removed from windows, doors should be kept locked and signs posted that residents are not permitted without staff and areas identified by marking the floor indicating where residents are not permitted to pass.

It is strongly recommended that facility cameras be maintained because some of the blind spots or areas where staff and residents could be out of sight of other employees, and since there are limited staff, the use of cameras could enhance investigations and prevent or deter sexual abuse.

Directive PREA-Compliant Staffing Plan 16-005 requires that the facility management and the facility PREA compliance manager approve the staffing plan semi-annually.

The staffing plan takes into account generally accepted detention and correctional practices and considers placement of cameras and staff to prevent, detect, and respond to sexual abuse and sexual harassment. Since this is ABRC’s first staffing plan, a review of the PREA Resource Center staffing plan webinar to prepare for the next staffing plan is recommended.

The ABRC staffing plan, in combination with interviews, confirmed that not all the required elements of the standard are included in this staffing plan.

There apparently has not been a time within the past 12 months when the facility needed to deviate from the staffing plan.

Policies currently in place, interviews and review of the facility staffing plan confirmed that the PREA Coordinator reviews the need for adjustments, staffing patterns, deployment of monitoring technology or if allocation of agency or facility resources to commit to the staffing plan are suggested.

A blank facility staffing plan review checklist was provided as a sample. Once a year, in collaboration with the agency’s PREA Coordinator, this should be reviewed. The PREA Coordinator confirmed that he participates in annual staffing plan meetings.

PREA Compliant Staffing Plan Directive 16-005 states that exceptions to the plan are documented in the Staffing Plan Exception Log.

Interviews indicated that all deviations from the staffing plan are documented. ABRC staff said they haven’t had to deviate from the staffing ratios.

Ratios

ABRC is required by policy to maintain staffing ratios of a minimum of 1:8 during resident waking hours and 1:12 during resident sleeping hours. During the past 12 months, there were no indications that the there was any deviation from the staffing plan or from the required ratios. However, in staff interviews it was apparent that due to the limited number of staff and responsibilities of staff to transport residents to meetings, appointments, school or community service appointments, meeting the staffing ratio or 1:8 is difficult. Security staff are the only employees who are included in the ratios. They are not permitted to transport more than eight residents at a time. However, by policy they are required to maintain the 1:8 ratio. ABRC is a reintegration center, not a secure facility.

PREA Compliant Staffing Plan - Directive 16-005 outlines the required staff-to-resident ratios.

Additionally, in 2006, CYFD entered into a non-litigious agreement with the American Civil Liberties Union (ACLU) that requires ABRC to ensure that residents are safe in CYFD facilities. One of the requirements is to increase staff in all living units so that the actual working staff-to-resident ratio for staff provide direct supervision on duty needs to be 1:8 during the day and 1:12 at night. The PREA standard requirement of 1:8 staff ratios during the day and 1:16 at night is for secure juvenile facilities. Directive 16-005 requires Reintegration Centers to oblige a 1:12 ratio. The ratio for reintegration centers allows staff to transport residents and still be able to supervise residents at the facility with the limited number of staff.

There are generally two security staff members on duty during the day and swing shift and one on duty during the graveyard shift. When staff transport residents, one staff might be on duty and sometimes the program supervisor/PREA compliance manager and program manager have to work a shift or fill in for security staff. The staff does a good job adjusting their schedules to accommodate the various requirements. However, it is recommended that an additional graveyard employee or staff that can work graveyard 2:00 am to 10:00 am shift or
swing shift into graveyard shift be considered to ensure ratios are met and one staff member is not alone with residents for an extended period of time.

Interviews indicated that all deviations from the staffing plan are documented. Staff said that it is difficult to maintain the ratios when they have to take residents to work, community service, education and/or appointments and still monitor residents at the facility. However, employees said that there hasn’t been an occurrence in which they deviated from the staffing ratios. Either the program manager or program supervisor fill in or security staff is called in.

Directive 16-005 PREA Compliant Staffing Plans was updated to require ratios for reintegration centers will be at least 1:12 during the day and at night. JJS administration may implement a lower employee-to-client ratio if warranted on a particular unit based on the type of program and security level needed.

Unannounced Rounds
During the tour of the facility, the auditor observed unannounced rounds by the program manager and PREA compliance manager (program supervisor). During interviews with staff, it was explained that supervisory rounds take place on day and swing shift only. The only two supervisory staff that make unannounced rounds are the program manager and program supervisor. Supervisory staff explained that they sometimes need to work a shift when other staff transport residents to and from work, community service, school or appointments.

ABRC requires that supervisors conduct and document unannounced rounds. Directive 16-002 states that supervisors must conduct and document unannounced rounds aimed to identify and deter employee sexual misconduct, including abuse and harassment. The rounds must occur daily and on every shift.

Staff members document these rounds in a log book/pass-on book. Examples were provided, and during the facility tour, a random log book was inspected. Rounds are not conducted on graveyard shift and they were not conducted daily. Following interviews, policy review, inspection of pass on-book and sample logs, it was determined that the facility is not complaint with this standard. On July 29, 2016, the Policy & Procedure Manager updated Directive 16-002 PREA Compliant Patrols and Inspections to the following: In Juvenile Reintegration Centers (JRCs), the frequency and timing of these rounds as outlined in post-orders.

**Required Corrective Action:**
1. Require supervisory staff to made random, unscheduled, unannounced rounds on graveyard shift.
2. Due to the limited number of supervisory staff, change the unannounced round requirements on each shift from daily to bi-monthly, enabling staff to conduct unannounced rounds on day, swing and graveyard shifts. Consider what is reasonable for reintegration centers.
3. The facility must develop post order to address the frequency of when unscheduled, unannounced rounds will be made.
4. Implement post order requirements.
5. Provide documentation for at least a month where unannounced rounds are made on all three shifts.

**Verification of Corrective Action:**
On November15, 2016, the PREA Coordinator provided post orders that require supervisory staff to make random, unscheduled unannounced rounds on all three shifts. Documentation that unannounced rounds were made on all three shifts was provided.

Policy, Materials, Interviews and Other Evidence Reviewed
ABRC Staffing Plan
ABRC Staffing Plan Assessment
Facility Staffing Plan Review Checklist
Agreement between ACLU and CYFD
PREA Compliant Controls and Inspection - Directive 16-002
PREA Compliant Staffing Plans – Directive – 16-005
Evidence of Rounds provided prior to on-site audit
Interviews with facility staff
Random review of log book during on-site audit
Pre-Audit Questionnaire completed by ABRC
On-site audit - on all shifts
Policies and Directives updates and emails from Policy & Procedure Manager

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.

ABRC staff members state that they do not conduct cross-gender searches or cross-gender visual body cavity searches of residents except in an exigent circumstance.

PREA Compliant Searches - Directive 16-001 PREA states cross-gender (frisk) searches are prohibited except in exigent circumstances that demand immediate action. Exigent circumstances must be documented on the Search Report. It states that all visual (strip) searches will be conducted with two employees present except in exigent circumstances that demand immediate action. These searches must also be documented on the search report.

In the past 12 months there were no cross-gender strip, cross-gender visual body cavity or pat-down searches of residents.

In interviews with staff and residents it was clear that these types of searches have not been conducted. Interviews with staff indicated that they are aware of this requirement and would document their actions if there were ever an exigent circumstance. ABRC staff said that searches of this type would be highly unlikely since there are adequate ratios of male staff.

ABRC provided a list of all security staff who attended the cross-gender/transgender pat search training. A total of 14 YCS staff attended the training.

PREA Compliant Client Privacy and Grooming - Directive 16-004 states that residents must be able to shower, perform bodily functions, and change clothing without non-medical employees of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental during routine room checks.

As part of the on-site tour of the facility, the auditor inspected every resident bathroom and shower area. There is one hallway that has six rooms. Four residents could be housed in each room but the program manager said that the maximum number of residents that can be housed at ABRC is 12. One room had three residents. There are three showers and two toilets on each side of the hall. Only one resident can shower at a time. Showers have curtains for privacy. One shower is missing a shower curtain and the auditor was told that it would be replaced. The program manager said that only male staff can supervise residents while they are showering. ABRC staff and residents said that female staff rarely come into the living unit area.

Female staff are required to announce their presence when going into the hallway where resident rooms are located and there is a sign that requires female staff to announce themselves before entering. The auditor observed staff making the announcement.

Residents dress and undress in the shower. They place their clothing and towel over the shower curtain. Hooks for residents to use to hold their clothing would reduce the residents having to place their clothing on the shower curtain. According to the vulnerability assessment and statements from staff, shower curtains with mesh tops and clear bottoms are going to be purchased to replace the existing shower curtains.

There are three closets in resident living areas that are used for storage of supplies and clothing for residents. Female staff said that they announce themselves before going into the area and get supplies from the closet during the day when they know residents are not in the facility. Non-security staff interviewed said that they do not go into the areas where the room and showers are located.
Currently, there is one female security staff member. Interviews with staff and residents confirmed that female staff announce themselves when going down the hall where residents may be in a state of undress, showering or performing bodily functions.

Residents are able to close the door to their room when changing clothes. In addition, the rooms have closets with doors. One resident said that he uses the closet door in his room to change clothing in privacy.

Interviews with staff and residents confirmed that female staff announce themselves when going down the hall where residents may be in a state of undress, showering or performing bodily functions.

Additionally, there are cameras that record the hallway and closet doors, and can identify who enters and exits the area. There are supply closets in the hallway before reaching the resident rooms and shower areas. Since non-security staff need to enter this area for supplies, the cameras are important to maintain and need to be routinely reviewed.

In interviews with staff and residents, it was determined that residents can undress, shower and perform bodily functions without being viewed by the opposite gender.

PREA Compliant Client Privacy and Grooming Directive 16-004 also requires opposite gender staff members to announce their presence prior to entering living units. There is a sign reminding opposite gender staff to make the announcement prior to entering the living unit. Interviews and observations indicate that this is being done. Residents confirmed the practice was occurring during all shifts.

PREA Compliant Searches - Directive 16-001 prohibits staff from searching or physically examining a resident for the sole purpose of determining the resident’s sexual anatomy. The facility indicated that no searches as described in this provision of the standard have occurred in the past 12 months.

Interviews with staff indicated they were aware of the requirement and said this had not occurred. At the time of this audit, there were no residents identified as transgender or intersex to interview.

PREA Compliant Searches - Directive 16-001 states that all searches pat (frisk), visual (strip), and non-invasive of transgender and intersex clients will be conducted with two employees present except in exigent circumstances that demand immediate action. Exigent circumstances must be documented on the Search Report. Policy states that “at intake, self-identified transgender and intersex clients may request the gender of the employees who will conduct their searches”. Preference is documented on a Client Search Exception Form and retained in the client’s file. The JJS Policy & Procedure Manager stated that the next time policy P.5.29 – Searches is updated, that clearer language will be incorporated stating that the client’s preferred gender of employee be used when searching the resident.

A training titled “Guidance in Cross-Gender and Transgender Pat Searches training” and training roster was provided as documentation that all staff received the training.

PREA Compliant Searches - Directive 16-001 requires that all JJS employees who conduct searches must complete the PREA Compliant Search Training.

The training was consistent with the requirements of the standard. Interviews with staff indicated they received this training and understand the requirements. The agency provides training on how to conduct cross-gender pat-down searches and searches of transgender and intersex residents in a professional manner.

Policy, Materials, Interviews and Other Evidence Reviewed
PREA Compliant Searches - Directive 16-001
PREA Compliant Client Privacy and Grooming Directive 16-004
Cross-gender/transgender pat search training rosters
Cross-gender and transgender pat searches training
Interviews with staff and residents
Pre-Audit Questionnaire completed by ABRC

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.

Policy P.4.13 Special Needs and Services Section 14, residents with mental illness or a developmental disability states that services are provided to residents with mental illness and developmental disabilities and referral sources are identified as needed. This can occur at intake or at any time during committal of a resident. Staff may identify symptoms of mental illness or indications of developmental disability and refer clients to behavioral health staff for further evaluation.

ABRC has a protocol for interpreter services and guidelines for American Sign Language and services for deaf or hearing impaired individuals to provide developmentally disabled residents equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

ABRC maintains a list of interpreters and identifies available state employees and locations to request interpreters in Spanish or Navajo. Facility staff said that interpreters for other languages have not been needed. However, the agency has a contract with a service that can provide interpreters, if needed.

The agency created a Client Handbook which includes a statement that the facility will provide information to the residents and their families or guardians that is easy to read and understand. It also states that the facility will “try” to provide information in the language that the resident or their family understands. Interpreter services are available by telephone, as well as translation services in a variety of languages. In an interview with the PREA Coordinator, he provided an example of one occasion when the translator service was used for a resident’s parents.

PREA staff training curriculum is included. It states that residents have the opportunity to report incidents. This includes residents with disabilities and those with limited English proficiency. It also states that when facilities create these reporting mechanisms, they must make these channels accessible to residents with disabilities and limited English proficiency.

Policy P.5.24 B, PREA Compliance – Client Education and Advocacy Section 4.3 states that residents who need language assistance are to be provided an interpreter and/or translation services.

There is a list of state employee interpreters and a process for requesting them. The facility has demonstrated the ability to provide residents and their parents or legal guardians with interpreters or translators. Additionally, the PREA brochure, poster and PREA education video are available in Spanish.

At the time of the audit, there were no residents at ABRC with disabilities or who were limited English proficient.

Policy P.5.24 B, states that other clients are never relied upon for interpreter and/or translation services. In the past 12 months there were no instances in which resident interpreters, readers or other resident assistants were used.

Interviews with random staff members indicated they were aware of this requirement. No residents were interviewed since there were none who were identified as being limited English or with a disability.

Policy, Material, Interviews and Other Evidence Reviewed
Policy 5.24 B, PREA Compliance - Client and Education Advocacy
Policy P.4.13 Social Needs and Services
CYFD translators per division List
Standard 115.317 Hiring and promotion decisions

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

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

Policy 5.24 A, PREA Compliance – Employee Preparedness Section 4.1-4.8 outlines the hiring of employees for JJS. Section 4.4 of the policy states that the CYFD conducts background checks on employees and contractors. The agency prohibits hiring or promoting employees or enlisting the services of contractors if they have engaged in sexual abuse in a confinement facility, been convicted of engaging or attempting to engage in sexual abuse in the community and/or been civilly or administratively adjudicated for sexual abuse.

Section 4.6 of the policy states that JJS administration considers any and all substantiated and unsubstantiated incidents of sexual harassment when determining whether to hire or promote any applicant.

Section 4.2 of the policy states that during the hiring process, JJS employee applicants are informed that in addition to an initial background check, CYFD receives notification (via the RAP Back Program) of any JJS employee involved in a triggering event, which includes a change in criminal history record information, a fingerprint verified arrest and/or a sex offender registration.

The Human Resource Director and Manager stated that criminal background records checks, child abuse registry checks and sex offender registration checks are conducted on applicants. The auditor reviewed examples of these checks for new hires, promotions, contractors and volunteers.

Section 4.4 requires an employee reference check from previous facilities’ employers. Elements of standard A and C have been met.

The agency provides information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a written request from an institutional employer where a former employee has applied to work.

CYFD employees are required to comply with the Code of Conduct. It was last updated in 2011. It is recommended that consideration be given to include sexual abuse protocols and/or ensure the PREA standards are included since they went into effect on August 20, 2012.

JJS policy 5.24 C requires that employees report sexual misconduct, including sexual abuse and sexual harassment. Section 1.3 states that all sexual contact between employees and clients; contractors, volunteers, or student interns and clients; and clients and clients, regardless of consensual status, is prohibited and subject to disciplinary action and possible criminal prosecution. Section 1.4 all JJS employees, contractors, volunteers and student interns are required to report any suspected or witnessed sexual misconduct. Section 15.2 states that an employee who fails to follow this procedure may be subject to disciplinary action in accordance with the CYFD Code of Conduct.

In interviews with the program manager, PREA Coordinator, human resource director and manager it was confirmed that new employees, contractors, volunteers and student interns undergo a criminal background records
check and child abuse registration and sex offender registration checks. ABRC staff said that five people were hired within the past 12 months and that each underwent criminal records background and child/abuse sex offender registry checks. CYFD consults child abuse registries before enlisting the services of any contractor that has contact with residents. Policy 5.24 C, Section 4.8 states that the JJS administration considers any and all substantiated and unsubstantiated incidents of sexual misconduct in determining whether to enlist the services of contractors. In the past 12 months there were no contractors who received criminal background record checks. ABRC has no contractors working at the facility.

Policy 5.24 A, Section 4.1 says CYFD conducts background checks of all applicants, potential JJS employees, contractors, volunteers, and student interns. Section 4.2 requires that CYFD receive notification on any employee involved in a change in criminal history records information, a fingerprint verified arrest and/or a sex offender registration. All employees, contractors, volunteers and student interns must be fingerprinted, and if they have law enforcement contact or were arrested, they are required to report it. Human resource staff said that if an employee has contact with law enforcement or is arrested, JJS is notified.

The human resource manager provided examples of criminal background records checks conducted on ABRC and agency volunteers and contractors to demonstrate compliance. An example of the following was reviewed: A criminal background records check, child abuse and sexual offender registry check, PREA questionnaire form that includes the questions required in standard 115.317 (a) 1-3 and verification of prior employer contracted was provided for a new hire for ABRC. A PREA questionnaire form was provided for an employee who was promoted. An employee who transferred to ABRC included the criminal background records check and PREA questionnaire form. Example of a volunteer and a contractor’s criminal background records check and PREA questionnaire form. It was unclear if the volunteer was from ABRC. As a result, a list of volunteers for ABRC was requested.

The PREA Coordinator stated that CYFD is in the process of hiring a Volunteer Coordinator to monitor and track all volunteers within the agency. A copy of the job description was provided. The position will ensure and monitor that all volunteers will have PREA training, sign PREA acknowledgement forms and pass a background records check prior to having contact with residents. Currently, all volunteers at ABRC are on hold until they receive PREA training and sign the PREA acknowledgement form verifying that they understand the training they received. The PREA Coordinator will provide the auditor with verification when ABRC volunteers criminal records background checks and PREA training is completed.

Policy 5.24 A, Section 4.1 says CYFD conducts background checks of all applicants, potential JJS employees, contractors, volunteers, and student interns. Highly recommend that criminal background records check and child abuse and sex offender registry checks are conducted on volunteers prior to having contact with residents.

The PREA Coordinator said that the Contract Coordinator will be responsible to monitor and track contractors within the agency to ensure they undergo a criminal records background check, contact prior institutional employers for information on substantiated allegations or sexual abuse or any resignation during ending investigations of sexual abuse, and check child abuse and sex offender registries. The Contract Coordinator ensures a contractor completes PREA training and signs the PREA acknowledgment form verifying they understand the training they receive prior to having contact with a resident.

The Program Manager and PREA Coordinator said that there are no contractors at ABRC.

Before hiring new employees who may have contact with residents, the agency shall perform a criminal background records check and consult any child abuse registry maintained by state or local agencies. The agency asks all applicants and employees about previous misconduct described in paragraph (a) in written applications for hiring or promotions. The agency also imposes upon employees a continuing affirmative duty to disclose any such misconduct. In the Code of Conduct there is a requirement to report arrest, charges or Protective Service referrals during off-duty hours to their supervisor the next business day. In an interview, the PREA Coordinator said that all employees are required to sign the Code of Conduct annually.
Human resources developed an annual PREA acknowledgement form to ask staff about sexual abuse outlined in 115.317 (a) 1-3. Human resources will begin having staff sign the form. It will then be signed annually along with the Code of Conduct.

**Required Corrective Action:**
1. Provide documentation that the facility staff have signed the Annual PREA Acknowledgement form.

**Verified Corrective Action:**
On November 17, 2016, the PREA Coordinator provided verification that facility staff signed the Annual PREA Acknowledgement form.

Applicants for hiring and promotions must complete the PREA questionnaire form. It contains the required questions from 115.317 (a) 1-3. The Human Resource Director confirmed that CYFD does not do written self-evaluations as part of reviews of current employees.

Policy 5.24 A, Section 7.7 states that an applicant who does not reveal any issues of sexual misconduct, but is later discovered to have a history of sexual misconduct, may be subject to disciplinary action, up to and including dismissal.

**Policy, Materials, Interviews and Other Evidence Reviewed**
Policy 5.24 A, PREA Compliant Employee Preparedness
Completed Pre-Audit Questionnaire competed by ABRC
Samples of PREA Questionnaire for new hire, promotion and transfer
Samples of background checks for new hire, promotion, contractor and volunteer
Interviews with PREA Coordinator, Human Resources Director and Manager.
Collective Bargaining Agreement – Union Contract
Code of Conduct
Sample of PREA for Prior Institutional Employees
Employment Practices Policy
Sample of the PREA Questionnaire and PREA Institution form
Pre-Audit Questionnaire completed by ABRC

**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)

**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.**

Since August 20, 2012, ABRC has not acquired a new facility or made a substantial expansion or modification to its facility.

Interviews with the program manager and PREA Coordinator indicated that there has been no expansion or modification and that they were aware of this requirement.

ABRC has not installed or updated video monitoring systems since August 20, 2012. ABRC has cameras. A camera plan is included in the staffing plan in standard 115.313. It is recommended that ABRC continue to maintain and update/add cameras.

**Policy, Materials, Interviews and Other Evidence Reviewed**
Pre-audit questionnaire completed by ABRC
Interviews with program manager and PREA Coordinator
PREA staffing Plan
Pre-Audit Questionnaire completed by ABRC

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.

ABRC refers allegations of sexual assault or sexual abuse to the New Mexico State Police for criminal investigations. New Mexico State Police follow policy OPR: 17 Evidence/Property Handling when required to preserve evidence and property. The policy is dated March 12, 2012.

Upon direction of New Mexico State Police, victims of sexual abuse or sexual assault are transported to Albuquerque SANE Collaborative for forensic sexual assault medical exams.

New Mexico Interagency Behavioral Health Safehouse Interviews and Family Advocacy Service have established procedures for an investigative forensic interview of victims of sexual abuse or sexual assault. The intent is to produce an interview of child sexual abuse, physical abuse, neglect, sexual assault by a child, or child witness to crimes of violence that is of evidence quality and visually recorded by electronic media, and also provide advocacy services. The Safehouse interview must be guided by a multi-disciplinary investigatory team, which consists of at least one of the following: law enforcement (local/county/state police), District Attorney’s Office, Licensing and Certification Authority, a case worker or social worker from Children, Youth and Families Department, Tribal Social Services, or Sexual Assault Nurse Examiner and Safehouse Interviewer(s).

ABRC will provide residents with a forensic medical exam conducted by a sexual assault nurse examiner upon request according to Policy 5.24 B Section 9.2. States that a client requesting a forensic medical exam is transported to a clinic and provided services and advocacy at no cost. These services are provided, regardless of whether the victim names the abuser and/or cooperates with the investigation. Residents are transported to the Albuquerque SANE Collaborative for forensic medical exams. Section 9.3 states that if requested by the client, a victim advocate accompanies and supports the client during the SANE exam and investigatory interviews. Additionally, the advocate provides the client emotional support, crisis intervention, information, and referrals.

ABRC did not provide a document that outlines their PREA coordinated response. However, policy and interviews confirm that reports of sexual abuse or sexual assault are referred to the Officer in Charge. Staff said in interviews that they needed to secure the crime scene, call for back up, call the officer in charge and wait for New Mexico State Police. There hasn’t been an incident of sexual abuse or sexual assault in the past 12 months according to interviews and documentation. It is highly recommended that ABRC develop a uniform evidence protocol for staff to follow. Also, implementing drills for staff so they remain prepared will help guarantee that usable physical evidence will be obtained in the event of a sexual assault or sexual abuse incident.

During the on-site audit, the Juvenile Justice Services Bureau Chief Performance/Policy Bureau was in the process of establishing the memorandum of understanding (MOU) with the Rape Crisis Center of Central New Mexico signed. On July 25, 2016, the signed MOU was provided. The Rape Crisis Center of Central New Mexico will provide residents who are victims of sexual assault or sexual abuse with access to a victim advocate during forensic medical exams and provide emotional support, crisis intervention, information and referrals.

ABRC provides victims of sexual abuse access to a forensic medical exam at no cost. Policy 5.24 B, Section 9.2 states that a resident requesting a SANE exam is transported to a clinic and provided services and advocacy regardless of whether the victim names the abuser and/or cooperates with the investigation.
Additionally, allegations of sexual abuse or sexual assault are reported to CYFD Protective Services. The PS Screener screens the allegation. The Office of the Inspector General (OIG) investigator conducts administrative investigations. The New Mexico State Police conduct criminal investigations. Both agencies, the New Mexico State Police and OIG investigator conduct their own investigations.

No residents have been referred for a forensic medical exam in the past 12 months.

Policy 5.24 B, Client Education and Advocacy, states that a resident can request that a victim advocate accompany and support them during a SANE exam and investigatory interview. The advocate provides the resident with emotional support, crisis intervention, information and referrals. On July 25, 2016, the signed MOU was provided to the auditor. The Rape Crisis Center of Central New Mexico will provide residents who are victims of sexual assault or sexual abuse with emotional support, crisis intervention, information and referrals. Residents can now be provided notification of these services.

Policy 5.24 B Section 8.3 and 8.4 provides for advocacy services from a rape crisis organization as well as a "qualified agency staff member" who is the BH clinician. All residents are assigned a BH clinician. If a report of sexual abuse is made, the BH clinician is also made available to provide in-house advocacy in addition to the outside victim advocate.

Policy, Material, Interviews and Other Evidence Reviewed
ABRC Behavioral Health therapist and nurse
New Mexico Interagency Behavioral Health Service Requirements and Utilization Guidelines Safehouse Interview and Family Advocacy New Mexico State Police Evidence Protocol Policy
Policy 5.24 B PREA Compliant – Client Education and Advocacy
Advocacy MOU CYFD with rape crisis center
State police letter
Albuquerque SANE Collaborative Website
Pre-Audit Questionnaire completed by ABRC

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.

Policy P 5.24 C, PREA Compliant Responding to Allegations section 4.2, states that all reports of sexual misconduct are considered credible and must be promptly investigated, regardless of the following circumstances: resident named is no longer in custody, the employee is no longer employed by CYFD, resident reporter has made false allegations previously, source of the allegation recants the allegation, the employee receiving the allegation does not believe the allegation is true and the resident reporter has developmental and/or cognitive disabilities. State police investigate criminal allegations of sexual abuse. Section 10.2 requires that all other investigations be suspended until law enforcement releases the case for administrative processing.

Documentation and interviews indicate that there were no allegations of sexual abuse and sexual harassment in the past 12 months.

An interview with an investigator with the Office of the Inspector General confirmed that she was aware of the requirement that all allegations are to be investigated. She said that she investigates all staff-on-resident sexual abuse
and/or sexual harassment allegations and that sometimes she needs to wait until the New Mexico State Police have investigated the allegation before she can complete her investigation.

An interview with the grievance officer verified that she was aware of the requirement to investigate all non-criminal resident-on-resident sexual abuse and/or sexual harassment allegations.

Policy 5.24 C, PREA Compliant Responding to Allegations section 10.1, states that if the incident is referred for criminal prosecution, law enforcement must conduct the investigation. Section 10.3 states that the Office of the Inspector General special investigator and/or a Protective Service investigator conducts an investigation of all allegations screened in by the Protective Services Screener.

Policy 5.24 C, Section 9 states that per CYFD SAP-03 stand-alone procedure (SAP), the protective service (PS) screener receives all incoming calls to the JJS Facility Confidential Reporting Number. If the caller alleges any sexual misconduct, the PS Screener immediately alerts the officer in charge. Then, per SAP-03, the PS Screener follows the guidelines for screening the allegation for the Office of the Inspector General investigation or for the Grievance Officer investigation.

During interviews, staff members were aware of who conducts criminal investigations. Some stated that to make a referral for investigation they would notify a supervisor or officer in charge.

Criminal allegations are referred to the New Mexico State Police. If the incident involves a staff-on-resident sexual abuse and sexual harassment, the report is referred to the OIG investigator and possibly the Employee Relations Bureau (ERB). If not criminal and if it is a resident-on-resident incident, the report is referred to the Grievance Officer.

The SAP reporting line is also available. This is a telephone line where clients, parents of clients and staff can report sexual abuse or sexual harassment.

Section 5 states that all employees are required to report sexual misconduct. They can do so in the following ways: notify a supervisor, call the toll-free JJS Facility Confidential Reporting number, write a confidential letter to the Protective Services, call the Statewide Central Intake Hotline, and/or Email and/or call the JJS PREA Coordinator.

Section 7 requires that when the officer in charge receives notification of an allegation of sexual misconduct, he/she is responsible for coordinating an immediate response which includes, but is not limited to, notifying law enforcement, if appropriate, calling the JJS Facility Confidential Reporting Number, making notification to management and initiating an administrative investigation.

In September 2016, residents will be able to write a confidential letter to the PREA Reporting Office in Las Cruces, New Mexico, which is an agency outside CYFD in place of writing a confidential letter to Protective Services. Protective Services is under the same agency as CYFD and the standard requires that residents be able to reports sexual abuse and sexual harassment to an outside agency. The Memorandum of Understanding is being reviewed by general counsel and then it will be signed by agency officials.

PREA standard requires the agency to have a policy requiring that allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, including the agency, if it conducts its own investigations, unless the allegation does not involve potentially criminal behavior. Staff were able to articulate that criminal investigations are conducted by the New Mexico State Police.

In the past 12 months there were reportedly no allegations of sexual abuse and sexual harassment. No investigations were available for the auditor to review.

PREA procedure and information on which entity investigates sexual misconduct, including sexual abuse and sexual harassment, is not posted on the website.

**Required Corrective Action:**
1. Provide documentation on the agency website that the New Mexico State Police conducts criminal investigations for sexual misconduct, including sexual abuse, sexual assault and sexual harassment.

**Verification of Corrective Action:**
On September 29, 2016, the PREA Coordinator provided documentation that the contract facility is working towards compliance with the PREA standards.

Policy, Materials, Interviews and Other Evidence Reviewed
Website - https://cyfd.org/facilities/prison-rape-elimination-act-prea
Policy 5.24 C PREA Compliant – Responding to Allegations
Pre-Audit Questionnaire completed by ABRC
Interviews with random staff
Interview with PS Screener
PREA coordinator report

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.

Policy 5.24 A, PREA Compliant - Responding to Allegations, Section 5 indicates that all employees will receive training. The policy indicates that training will include all the components covered in 115.331 (a) (1-10). Section 5.5 states that after the initial training, CYFD will conduct annual refresher training.

The training curriculum demonstrated that all components required in (a) (1-10) are covered in the training. The training curriculum notes on Slide 14 confirm that staff are trained every two years. The required elements are included in the lesson plan.

ABRC states that employees who are reassigned from facilities housing opposite gender are given additional training.

ABRC requires employees to receive PREA training every other year. A memo was included from the PREA Coordinator outlining the following: In the years they do not receive training, employees receive a quarterly newsletter that is distributed by email. Then the facility PREA compliance managers cover the topics in the PREA newsletter in their meetings with facility staff.

Policy 5.24 Section 5.5 states that in addition to the initial training, CYFD conducts mandatory refresher courses allowing all JJS employees to recertify in PREA training every year. According to interviews with the PREA Coordinator, employees will not receive refresher training yearly, but instead will receive a quarterly newsletter.

The auditor recommends that the policy be changed to reflect what is actually occurring. On July 12, 2106, the Policy & Procedure Manager provided these changes to Policy 5.24 Section 5.5 In addition to the initial training, CYFD conducts mandatory refresher courses so that all JJS employees recertify in PREA training every other year.

After reviewing the PREA curriculum, conducting interviews with staff and reviewing a variety of educational information provided to employees, the facility has met the training requirement as outlined in this standard.

All employees have received PREA training. Training certifications were provided to verify compliance. One employee is on extended military leave and has not been trained. The program manager said that when the employee returns, PREA training will take place.
Policy 5.24 section 5.4 requires that all employees sign a document indicating that they understand the training they have received and understand that they serve as mandatory reporters. PREA training acknowledgement forms were provided for all employees to verify compliance.

Additionally, the PREA Coordinator stated that all ABRC staff have received PREA training and signed acknowledgement forms. The auditor requested additional PREA training and the signed acknowledgement forms for staff who do not consistently work at ABRC. Training records were provided for the superintendent, OIG investigator, grievance officer, medical administrator and nurses who dispense medication.

Policy, Materials, Interviews and Other Evidence Reviewed
Policy 5.24 A, PREA Compliant – Responding to Allegations
Training Curriculum
JJS NEO CORE SAP02 – updated 2-4-14
Explanation of education between trainings
Quarterly Newsletter
Pre-audit questionnaire completed by ABRC
Interview with PREA Coordinator
PREA training certifications for PREA: Your Role Responding to Sexual Abuse
PREA training acknowledgement forms
Policies and Directives updates and emails from Policy & Procedure Manager

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.

Policy 5.24 A, PREA Compliant – Employee Preparedness, Section 5.3 states that volunteers and contractors will receive training in order to work in a CYFD facility. A copy of the link to the National Institute of Corrections (NIC) PREA online training was included. Contractors and volunteers are required to complete the section entitled “Your role: responding to sexual abuse.”

No contractors were interviewed. The facility management staff and PREA Coordinator said ABRC did not have contractors.

An interview with a volunteer indicated the volunteer did not receive PREA training. The volunteer was aware of expectations to report sexual misconduct and that the agency had a zero-tolerance policy. The volunteer stated this information was learned through the program manager.

ABRC says that it maintains documentation that volunteer understand the training received. A list of volunteers, PREA training and acknowledgement forms for these volunteers was requested. The list was not provided.

The PREA Coordinator said that CYFD is in the process of hiring a Volunteer Coordinator to monitor and track all volunteers within the agency. The position will ensure and monitor that all volunteers will have PREA training, sign PREA acknowledgement forms and pass a background records check prior to having contact with a resident. Currently, all volunteers at ABRC are on hold until they receive PREA training and sign the PREA acknowledgement form that they understand the training they received.

The PREA Coordinator said that the Contract Coordinator is responsible to monitor and track contractors within the agency to ensure that they undergo a criminal records background check, contact prior institutional employers for information on substantiated allegations or sexual abuse or any resignation during ending investigations of sexual
abuse and child abuse and sex offender registries and are provided PREA training and sign the PREA acknowledgment form verifying they understand the training they received prior to having contact with a resident. ABRC does not have contractors.

**Required Corrective Action:**
1. Provide a list of ABRC volunteers
2. Provide documentation that volunteers have received the PREA training.
3. Provide signed PREA acknowledgement forms to confirm that they understand the training they received

**Verification of Corrective Action:**
On October 27, 2016, the PREA Coordinator provided verification that contractors received PREA training and signed the PREA acknowledgement form. The contractors that work at ABRC also work at the Albuquerque Girls Reintegration Center and Camino Nuevo Youth Corrections because the facilities are located in the same area of the city.

On October 27, 2016, the PREA Coordinator provided, verification that volunteers received PREA training and background checks.

Policy, Material, Interviews and Other Evidence Reviewed
NIC training curriculum link for Sexual Abuse training
Policy 5.24 A, PREA Compliant – Employee Preparedness
Interview with volunteer
Interview with PREA Coordinator
Pre-audit questionnaire prepared by ABRC
Blank PREA training acknowledgement for volunteers and contractors
PREA training acknowledgement forms signed by volunteers

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.**

Policy 5.24 B, PREA Compliant Client Education and Advocacy, Section 4 states that within the first 72 hours of arriving at JJS Central Intake, residents are given a comprehensive orientation which includes definitions of sexual misconduct – including sexual abuse and sexual harassment, the zero-tolerance policy and how to report sexual misconduct. The orientation also includes a resident’s right to be free from sexual misconduct, protection from retaliation and the right to treatment and counseling. Residents are given a client handbook and brochure at intake. The client handbook contains information about PREA, the agency’s zero-tolerance policy, the definition of sexual misconduct, and how to report sexual misconduct and retaliation. Residents sign a form indicating that they were educated regarding the agency’s zero-tolerance policy, definitions, ways to report, information that retaliation for reporting sexual abuse or sexual harassment will not be tolerated and that the facility provides protection to all victims and witnesses.

Each time the resident moves to another facility, the resident receives a comprehensive offender education about PREA within 10 days. Generally, on the first day of entering ABRC, the resident receives the comprehensive PREA education. Residents also are given a client handbook and brochure at intake. The client handbook contains information about PREA, the agency’s zero-tolerance policy, the definition of sexual misconduct, and how to report sexual misconduct and retaliation. Residents sign a form indicating that they were educated regarding the agency’s zero-tolerance policy, definitions, ways to report, information that retaliation for reporting sexual abuse or sexual harassment will not be tolerated and that the facility provides protection to all victims and witnesses.
ABRC reports that there were 53 residents admitted to the facility. All were given comprehensive age-appropriate information upon intake.

As part of the orientation process residents watch a video, which includes definitions of sexual misconduct including sexual abuse and sexual harassment, the zero tolerance policy and how to report sexual misconduct. The orientation also includes residents’ rights to be free from sexual misconduct, protection from retaliation and the right to treatment and counseling. Staff members stop the video at intervals to discuss content and make sure that residents understand what is being presented. The video is available in English and Spanish. Visually impaired residents can be provided the PREA information orally, and limited English proficient residents would be given the PREA information in a language they understand.

An interview with the PREA Coordinator indicated that the ABRC will change the intake orientation to provide residents with information about the agency’s zero-tolerance policy and how to report. This information is provided when the Intake staff goes over the client handbook, posters and brochure. Then within 10 days of Intake, the resident will receive comprehensive PREA education. This will include the resident viewing the PREA orientation video and a staff member discussing the video’s content. This process can include a review of the brochure and client handbook again.

ABRC reports that there were 53 residents admitted to the facility in the past 12 months. All were given comprehensive age appropriate information upon intake. The residents come from Camino Nuevo Youth Center, Youth Diagnostic and Development Center and John Paul Taylor Center.

Policy 5.24 B, PREA Compliant Client Education and Advocacy Section 4.3-4.5 states that orientation information for residents who need language assistance is provided. Services provided are interpreter and/or translation services. Special accommodations for residents who are deaf, visually impaired or otherwise disabled are made for developmentally appropriate services. Additionally, written material and model language material is provided in order to ensure effective communication with disabled, special-needs (limited reading skills) and non-English speaking residents. The program manager and PREA Coordinator said accommodations would be made if the need arises.

ABRC maintains documentation of residents’ participation in PREA education. The auditor reviewed residents’ PREA orientation checklists and Acknowledgement of PREA information. Interviews with residents and staff also confirmed that they received PREA education.

The auditor observed the intake of a new resident and noted that the resident received PREA education.

Residents receive a client handbook and brochure. Posters are available throughout the facility upon entry into the facility, near living unit, visiting/dining area and the staff station.

The agency ensures that key information about PREA policies are continuously and readily available or visible on posters and in client handbooks.

Policy, Materials, Interviews and Other Evidence Reviewed
Policy 5.24 B, PREA Compliant Client Education and Advocacy
Pre-audit Questionnaire completed by ABRC
Client handbook
PREA Brochure – English and Spanish
PREA Poster – English and Spanish
Offender orientation PREA video
CYFD-JJS PREA Orientation Checklist
Interviews with residents
Interviews with PREA program manager, PREA compliance manager and PREA Coordinator

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.

JJS conducts administrative investigations and the New Mexico State Police conducts criminal investigations. Policy 5.24 A, PREA Compliant Employee Preparedness, Section 6.2 states that all facility PREA compliance managers, OIG employees, and grievance officers are required to complete training for PREA investigators.

The training curriculum was provided for auditor review. It is the on-line NIC PREA training for investigating sexual abuse in a confinement setting that the PREA compliance managers, OIG employees, and grievance officer are required to complete. The training is specifically designed for conducting sexual abuse investigations in confinement settings.

The training that the OIG and grievance officer received includes the mandatory elements in the PREA standard, including interview techniques, sexual abuse evidence collection in a confinement setting, trace evidence collection in confinement settings, criteria and evidence required to substantiate a case for administrative action or prosecution referral, as well as proper use of Miranda and Garrity advisements. During interviews, the OIG investigator and the grievance officer were able to articulate an understanding of all requirements of the standard.

Additionally, the agency maintains certifications for the employees who have completed PREA: Investigating Sexual Abuse in a Confinement Setting training. The OIG investigator and Grievance Officer were interviewed and copies of the PREA specialized investigator training certificates were provided.

Policy, Material, Interviews and Other Evidence Reviewed
Policy 5.24 A, PREA Compliant Employee Preparedness
Training Curriculum
Investigator certificates for specialized training
Pre-audit questionnaire completed by ABRC
Interview with OIG investigator and Grievance Officer

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.

Policy 5.24 A, PREA Compliant Employee Preparedness, Section 6.5-6.8 states that all Behavioral Health (BH) clinicians are required to complete specific training for BH practitioners. All BH clinicians are required to complete victim advocacy training and receive continuing education on sexual assault, forensic examinations and victim services. Medical employees are required to complete specific training for medical responders to PREA incidents.

Include in policy that all full and part-time medical and mental health care practitioners who work regularly in its facilities be trained in:
(1) Detection and assessment of signs of sexual abuse and sexual harassment;
(2) Preservation of physical evidence of sexual abuse;
(3) Responding effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and
(4) Proper reporting allegations or suspicions of sexual abuse and sexual harassment.

The training curriculum for both medical and mental health was provided as documentation. Both trainings are detailed and cover all topics required by this standard.

There is one mental health staff member at the facility, and verification that that she received specialized training was provided.

Medical care is provided at local hospitals because there is no medical care offered at ABRC. Nurses from Camino Nuevo Youth Center come to the ABRC only to dispense medication.

Interviews with medical and mental health staff indicate that they received and understood the training. The specialized training received by medical staff is the NIC PREA: Medical Health Care for sexual assault victims in a confinement setting and behavioral health employees receive the PREA: Behavioral Health care for sexual assault victims in a confinement setting.

Standard B is not applicable. This provision of the standard is not applicable, because ABRC does not have any medical staff who conduct forensic examinations. All forensic examinations are done at the hospital.

Medical and mental health practitioners shall also receive the training mandated for employees under standard 115.331 or for volunteers and contractors under standard 115.332. Training records for all nurses who come to ABRC to dispense medication were reviewed. The training record for the behavioral health was provided. Medical and mental health clinicians have received specialized training.

Policy, Materials, Interviews and Other Evidence Reviewed

Policy 5.24 A, PREA Compliant Employee Preparedness

Pre-audit questionnaire prepared by ABRC

Interviews with medical and mental health staff

NIC training for Medical Health Care for sexual assault victims in a confinement setting

NIC training for Behavioral Health care for sexual assault victims in a confinement setting

Behavioral Health training certificate

Medical training certificates

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.

Policy 5.24 B, PREA Compliant Client Education and Advocacy, Section 5 states that within 72 hours of a resident’s arrival, a vulnerability assessment is conducted to obtain information to protect the resident from being the victim of or engaging in sexual misconduct. Since February 2016, 27 residents were screened for risk of sexual victimization or risk of sexually abusing other residents.

The Vulnerability Screening form was reviewed and required elements 1-11 are included. The auditor recommended that “boys wearing makeup” in the inappropriate physical behavior category be removed. Additionally, any gender nonconforming appearance and whether the resident may therefore be vulnerable to sexual abuse needs to be added. Once changed, the agency needs to begin using the updated screening tool in all facilities.
A screening is conducted upon intake to ABRC. Usually this screening is completed the day the resident arrives but no later than 72 hours after arrival, as required by the standard. Screenings are conducted in a private area. There was a resident who arrived on the second day of the on-site audit and the auditor observed the intake process.

Policy 5.24 B states that another assessment must be conducted within 30 days of the resident’s commitment, at every new orientation/transfer, and after every alleged incident of sexual misconduct. The case manager completes this assessment.

The Intake staff (PREA compliance manager) complete the assessments. The assessments are done in private and the results are kept in a confidential location. ABRC began using the screening instrument in February 2016.

Several random samples of 72-hour and 30-day screenings were reviewed on-site. Another example of a 30-day screening was requested after the on-site audit. Two residents were at the facility longer than 30 days. Interviews with residents showed that they were assessed within the required timeframe.

A blank copy of the Vulnerability Assessment Instrument: Risk of victimization and/or Sexually Aggressive Behavior/Violent Behavior form was provided.

After the initial assessments, staff also conduct assessments at six-month intervals and after a PREA incident. The residents’ average length of stay is three months.

The assessment identifies residents who are vulnerable to victimization, sexually aggressive and/or violently aggressive. Placement recommendations are made based upon the assessment.

Interviews with intake staff indicated a clear understanding of the requirements under this standard. A review of assessments confirmed that they were being conducted and used to determine placement as per standard 115.342.

Policy, Materials, Interviews and Other Evidence Reviewed
Policy 5.24 B, PREA Compliant – Client Education and Advocacy
Vulnerability Assessment Instrument: Risk of Victimization and/or Sexually Aggressive Behavior/Violent Behavior assessments
Examples of 72 and 30 days Vulnerability Assessment Instrument: Risk of Victimization and/or Sexually Aggressive Behavior/Violent Behavior assessments
Pre-audit questionnaire completed by ABRC
Intake with PREA compliance manager who conducts the vulnerability assessments
Interviews with residents

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.

Policy 5.24 B, PREA Compliant - Client Education and Advocacy Section 6.1 requires that information collected during a resident’s intake drives housing and programming assignments with the goal of optimizing rehabilitative and educational services and keeping all residents safe from sexual misconduct. A recommendation was made by the auditor to include “education” in the policy, and the agency made changes. The JJS Policy & Procedure Manager made the following policy changes: Section 6.1 requires that information collected during a resident’s intake drives housing, education, and other programming assignments with the goal of optimizing rehabilitative and educational services and keeping all residents safe from sexual misconduct.
Procedure P.21.9, 10, 12, 13 and 14, Classification and Programs, describes a multidisciplinary team that determines placement based upon needs/risk. There is also a placement and follow-up recommendation that the intake or case manager makes during the vulnerability and risk screening.

During interviews with the auditor, the ABRC staff and agency administrators stated that they do not use isolation. Procedure P.21.18, Room Confinement Section 11 and Procedure P.4.14, outlines room confinement procedure. According to policy, room confinement is used during some routine operational proceedings and emergency/crisis events. Room confinement is never used for non-compliance, discipline, punishment, or for the convenience of employees. During room confinements, clients are confined in their rooms for the shortest time necessary to de-escalate the client, control the situation or perform necessary employee duties. If a resident poses an immediate and substantial risk to self, others or the security of the facility, and lesser means of intervention have failed to control behavior, the resident may be confined to their room. Emergency notification protocols are then put into place. The protocols include being evaluated by behavioral health. The resident is checked a minimum of every two hours.

Additionally, residents are permitted to attend education classes or work. Residents are also given the opportunity to exercise.

Medical and Behavioral Health Services P.4.13, Section 14.9, states that services be provided to victims of sexual assault. Medical and psychological trauma of a sexual assault is minimized by prompt and appropriate intervention. Section 17 refers to care of clients physically separated from the population. Whenever separation is imposed, only approved methods are used in compliance with approved departmental separation procedures at 8.14.5.43. When a client is physically separated from the rest of the population, the appropriate employees monitor the client to be sure he has the opportunity to request care for medical or behavioral health issues. In interviews with medical staff, it was stated that room confinement could be used and that the abuser would be removed from the facility.

ABRC staff said that a client cannot be physically separated from the rest of the population at this facility. If separation was required, then the resident would be removed from the facility and provided medical and behavioral health care at another facility.

Medical, mental health and facility administration employees said that no residents have been isolated during the past 12 months.

Policy 5.24 B, PREA Compliant – Client Education and Advocacy Section 6.1 outlines that the information that employees collect during the resident’s intake drives housing and programming assignments with the goal of optimizing rehabilitation and education services while keeping all residents safe from sexual abuse. During interviews with facility and agency administrators, it was stated that residents are screened to coming to ABRC. Residents are not automatically placed at the facility.

Policy 5.24 B, Section 6.2 requires that residents cannot be assigned special housing solely because of LGBTQI status. During interviews with residents and staff, there was no indication that this was in practice at ABRC.

Policy 5.24 B, Section 6.3 - 6.4 states that housing assignments of transgender and intersex residents will be evaluated on a case-by-case basis. An executive multi-disciplinary team considers the residents’ needs and preferences, potential vulnerability, rehabilitation and education when recommending housing assignments. The executive multi-disciplinary team must review the initial housing assignment of transgender and intersex residents at least once a week until the multi-disciplinary team determines housing assignment. Thereafter, the multidisciplinary team reviews the housing assignment.

Interviews with staff indicated compliance with this subsection of the standard.

There were no residents that identified as transgender or intersex to be interviewed.

On July 12, 2016, the JJS Policy & Procedure Manager provided documentation that the Directive was updated. Directive 16-004 states that Transgender and intersex clients must be able to shower separately from other clients. All clients may request to shower separately from other clients. All clients may have the opportunity to wear under clothing and groom themselves according to their gender identity. Additionally, hygiene products (make-up, nail-polish) and permitted grooming process (leg, underarm, face shaving) may be available to clients regardless of their assigned sex at birth or their housing assignments.
Attire and grooming requests are considered on a case-by-case basis. An Executive Multidisciplinary Team will give serious consideration to the client’s preference and potential vulnerability.

During the on-site tour, the auditor reviewed every shower room in the facility. There are two shower areas, each with three showers. In a previous standard, a recommendation was made to replace a missing shower curtain. Residents shower individually while a staff member stands outside in the hallway. Residents have the ability to shower privately.

Policy, Materials, Interviews and Other Evidence Reviewed
Policy 5.24 B, PREA Compliant – Client Education and Advocacy
Updated Directive 16-004 PREA Compliance – Client Privacy and Grooming
Pre-audit questionnaire completed by ABRC
Procedure P.21.9, 10, 12, 13, 14 Classification
Procedure P.21.18, room confinement
Procedure P.4.13, special needs and services
On-site tour
Interviews with staff
Interview with medical administrator and nurse
Interviews with residents
Transgender and Intersex Client Search Preference Form
Policies and Directives updates and emails from Policy & Procedure Manager

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.

Residents at ABRC are provided multiple avenues to report sexual misconduct and retaliation. Upon intake into the agency and whenever they transfer, residents receive information about how to report sexual misconduct and retaliation. When residents arrive at ABRC, they are educated about reporting via a client handbook and comprehensive PREA education that they receive within 10 days of their arrival, a brochure and via posters displayed throughout the facility. The reporting methods are also outlined in policy 5.24 C, PREA Compliant – Responding to Allegations, Section 4.1 encourages clients who are victims of or witnesses to any sexual misconduct to make a report. Residents can make reports in several ways:
Notifying any employee, contractor, volunteer or student intern
Calling the toll-free reporting number
Writing a confidential letter to the Protective Services (This reporting method will change in September.)
Calling the statewide central intake hot line
Emailing and/or calling the PREA Coordinator
Requesting to see medical or behavioral health, or
Submitting a grievance

Anyone can report an allegation of sexual misconduct using these methods.
In September 2016, residents will be able to write a confidential letter to the PREA Reporting Office in Las Cruces, New Mexico which is an agency outside CYFD in place of writing a confidential letter to Protective Services. Protective Services is under the same agency as CYFD and the

Information about how to report is outlined in the client handbook, on posters, in the PREA brochure and in policy 5.24 C.
Residents must get permission to use the telephone. A staff member dials the telephone number for the resident.

If a resident calls the toll-free reporting number and the individual who staffs the line is not in, the resident can leave a voice message. If the resident leaves a name and contact information, the reporting-line staff returns the call. The reporting-line staff member must ask to speak to the resident and then staff contact the resident who then takes the call.

Residents also can file written reports of sexual abuse or sexual harassment to Protective Services. However, CYFD developed a new process for residents to report to the PREA Reporting Office in Las Cruces, New Mexico. This office is outside the agency and the process is anticipated to be effective in September 2016. The MOU is currently being reviewed by general counsel and then will be signed by agency administrators. Forms and self-addressed envelopes are available. Offenders can fill out the form and submit it in a grievance box. The grievance officer is responsible to collect envelopes addressed to CYFD Protective Services, stamp and mail them. The Grievance Office says that she checks the grievance box once a week. Using this option, a resident can report sexual abuse or sexual harassment anonymously.

Residents are informed in the client handbook, posters and/or brochure on the ways CYFD provides to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. The word “retaliation” is mentioned in the brochure and on the anonymous reporting form. It wasn’t included in the 2010 version of the client handbook. However, the client handbook is currently in the process of being updated. JJS is committed to providing a safe and secure environment, free from all forms of sexual misconduct and retaliation. Therefore, it is important to notify residents and staff that CYFD has zero-tolerance for sexual abuse, sexual harassment and retaliation. Additionally, retaliation for reporting sexual abuse or sexual harassment is not tolerated, and adding it to policy as well as the new versions of the client handbook, brochures and posters is strongly recommended.

On July 12, 2016, the Policy & Procedure Manager provided changes that were made to both the client handbook and policy 5.24 C. Policy 5.24 C Section13.2 now states that to protect from retaliation, JJS employs multiple measures that can include housing transfers for clients, non-client contact assignments for employees, and additional support services for anyone who fears retaliation for reporting sexual misconduct and/or participating in investigations. In addition, the Client and Family Handbook was updated under the “Did you know” section now includes, “You have the right to be free from retaliation.”

**Required Corrective Action:**
1. Provide a copy of the signed MOU with the outside reporting agency.
2. Educate residents about the outside reporting option and how to report.
3. Provide documentation that residents have received the notification.

**Verification of Corrective Action since the Audit:**
On July 12, 2016, the JJS Policy & Program Manager provided updated changes to Policy 5.24 C. Section 5.2 and 5.4 now state: “Additionally, all employees must immediately report and document any allegations received by third parties made verbally, in writing, or anonymously. Section 5.3 “To report any allegations of sexual misconduct, employees, contractors, volunteers, and student interns must notify the Office in Charge (OIC) immediately.” Section 5.4 These are additional methods to report allegations of sexual misconduct:
- Notify a supervisor
- Write a confidential letter to the PREA Reporting Office in Las Cruces, New Mexico
- Call the toll-free JJS Facility Confidential Reporting Number. The JJS confidential Reporting Number is staffed by a Protective Screener Monday – Friday 0800 – 1700. The Protective Screener checks for phone messages at least once every 24 hours to see if a message has been recorded.
- Call the Statewide Central Intake Hotline and/or
- Email and/or call the JJS PREA Coordinator

The facility does not retain residents solely for immigration purposes

The standard requires the agency to provide at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency. On July 25, 2016, the Bureau Chief Performance/Policy Bureau provided the MOU between CYFD and the New Mexico Department of Corrections. Residents will also have a way to report to an outside agency. In September, the residents will be able to send a confidential letter to an
outside agency by mailing it the PREA Reporting Office P.O. Box 639 Las Cruces, New Mexico 88004. Residents still need to be informed about this option.

The agency will make a form and envelope addressed to the PREA Reporting Office. Residents will be able to make reports anonymously by not including their name. The envelope can be placed in the grievance box for the Grievance Officer to mail.

On July 25, 2016, copies of the updated brochure and posters were provided. They list the PREA Reporting Office information.

CYFD does not detain residents solely for immigration purposes. Offenders who are held for civil immigration or who are Mexican citizens are provided with information on how to contact the Consulate of Mexico in Albuquerque. There is a memorandum of understanding between the agency and the consulate general.

There are no residents currently in ABRC detained solely for civil immigration purposes.

During the site visit, the auditor saw PREA posters that outline reporting options. The posters are visible by the living unit hallway and elsewhere throughout the facility. The residents also are given a handbook and brochure with reporting information. Interviews with residents verified that they were aware of how to report a PREA allegation.

Policy 5.24 C, PREA Compliance Responding to Allegations, Section 5.1 and 5.2 - 5.1 states that all employees must immediately report abuse and neglect, including any and all substantial risk, suspicion, information, or knowledge of sexual misconduct. 5.2 Section states that all employees must immediately report any allegations received by third parties made verbally, in writing or anonymously.

Interviews with staff at the facility indicated they understood the need to accept a report, no matter how that report comes to them. Staff said that they would report to their supervisor or the office in charge. Some said they would also call the SAP 02 line. PREA Standard 115.351 C requires staff members to accept all reports made verbally, in writing, anonymously, and from third parties and that they promptly document any verbal reports. Once a resident reports sexual misconduct, it is the staff’s responsibility to immediately report it to the Officer in Charge.

Policy provides employees with reporting options for sexual misconduct, and employees are required to immediately report abuse and neglect. Employees can report sexual misconduct by notifying their supervisor, calling the toll-free confidential reporting number, writing a confidential letter to Protective Services, calling the statewide central intake hot line or via email/call to the PREA Coordinator. Policy 5.24 C was updated to require that all reports of sexual misconduct are immediately reported to the Officer in Charge. Effective September 2016, residents will be able to write a confidential letter to the PREA Reporting Office in Las Cruces, New Mexico instead of CYFD Protective Services.

Required Corrective Action:
1. Policy 5.24 C was updated. Provide documentation of when policy goes into effect and when employees, contractors, volunteers, student interns and residents are trained on the changes.

Verification of Corrective Action since the Audit:
Policy 5.24 C was changed. Section 5.1 requires that “All employees, contractors, volunteers, and student intern must immediately report abuse and neglect, including any and all substantiated risk, suspicion, information, or knowledge of sexual misconduct.” 5.2 requires that “all employees must immediately report and document any allegation received by third parties made verbally, in writing, or anonymously.” 5.3 states that “to report any allegations of sexual misconduct, employees, contractors, volunteers, and student interns must notify the officer in charge immediately.” 5.4 provides additional methods to report allegations of sexual misconduct. They are to “Notify a supervisor, Call the toll-free JJS Facility Confidential Reporting Number, Call the Statewide Central Intake Hotline and/or Email and/or call the JJS PREA coordinator.”

On October 13, 2016, the PREA Coordinator provided verification stating that employees, contractors, volunteers and student intern and residents were trained on the changes to Policy 5.24C.

Staff can privately report using the same methods as the residents which are:
Notify their supervisor
Call the toll free JJS facility confidential reporting number
Write a confidential letter to Protective Services (This reporting method will change in September.)
Call the statewide central intake hotline
Email and/or call the JJS PREA Coordinator

Interviews with staff indicated they understood how to access these reporting options.

Policy, Materials, Interviews and Other Evidence Reviewed
Policy 5.24 C, PREA Compliant – Responding to allegations
Updated Policy 5.24 C, PREA Compliant-Responding to allegations
Final draft PREA brochure
Final draft PREA poster
Third-party reporting MOU
MOU client’s right to contact Mexican Consulate Verbal Report documentation
Pre-audit questionnaire completed by ABRC
Interviews with staff and residents

Standard 115.352 Exhaustion of administrative remedies

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

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

The agency has a formal grievance policy. In addition, the client handbook informs residents of the grievance process. The agency has administrative procedures to address grievances that includes physical abuse, sexual abuse and sexual exploitation and neglect. Rights of Grievance Complaint and Appeal P.20.15, Section 8.1.1 states that the JJS grievance process shall: provide a trackable way for clients or the client’s parents/guardian to voice grievances about a client’s care and treatment, provide a written and oral orientation upon intake for clients and clients’ families/guardians describing policies and procedures, and promptly update orally and in writing all clients and clients’ families/guardians about changes. The grievance definitions include sexual abuse and sexual exploitation. Retaliation is also mentioned. The Client and Family Handbook is in the process of being updated.

Directive 16-003 PREA Compliant Grievance Procedure states that grievances alleging sexual misconduct must be investigated regardless of any previously identified time limits for other types of grievances. A resident is never expected to resolve an allegation of sexual abuse informally with a JJS employee.

The facility has a grievance officer whose job is to investigate sexual misconduct grievances for resident-on-resident reports that are not criminal. The grievance officer explained how she conducts investigations during her interview.

Per P.20.15, Right of Grievance Complaint and Appeal, grievances must be filed within 30 days of the incident. However, grievances that allege sexual misconduct must be investigated regardless of any previously identified time limits for other types of grievances.

Section 10.2 states that grievances shall be responded to within five (5) business days following the date the grievance was filed. If the grievance required an Employee Relations Bureau (ERB) investigation, the Grievance Officer shall provide a response on non-personnel related actions within 5 business days. On personnel actions the ERB will be responsible for resolution recommendations at the conclusion of the ERB investigation.
Section 10.3 states that all grievances alleging staff misconduct that does not rise to the level of an abused resident will have an ERB employee assigned to the investigation. The ERB will generate a report concerning any possible disciplinary actions separately from the grievance response.

Section 12.3 states that if necessary, the JJS Deputy Director of Facilities or JJS Director will forward the response findings to the appropriate Facility Superintendent, Director of Facilities BH, Medical, or Education.

12.3.1 The appropriate Superintendent/Program Director will respond to each finding within five (5) business days and provide a proposal to address each finding with a timeline to complete the tasks involved.

12.4 Upon receipt of the Superintendent/Program Director’s response to findings, the JJS Director/Deputy Facilities Director shall review the response(s) within five (5) business days and

12.4.1 approve and direct the Superintendent or other responsible party to implement; or

12.4.2 disapprove and direct action to be taken to address issues, with timelines; and

12.4.3 when appropriate, draft a Corrective Action Plan (CAP) that is sent to the Office of the Secretary for information.

12.5 The JJS Deputy Director of Facilities:

12.5.1 Tracks implementation of Superintendent/Program Director action; and

12.5.2 Meets with the facility Superintendent(s) or appropriate program director at least once a month to review status of actions.

Section 13.1 states that a grievant may appeal the decision of a Grievance Officer to the JJS Deputy Director of Facilities in writing within five (5) business days of the date the grievant received the response:

The Stand Alone Policy-03 (SAP-03) Section 9.9 requires Completion of the OIG Investigation: The Special Investigator investigation is completed within a reasonable timeframe, which will typically be less than 30 calendar days of receipt of the referral. The Inspector General may grant an extension for completion based upon good cause. Any extension granted and the basis for the extension is documented in writing and approved by the Inspector General. Completion of the Special Investigator investigation entails completing the “Facility Investigation Form” and the "Facility Investigation Summary" which must be approved by the Inspector General.

Regardless of any extension, the investigation and exit staffing must be complete within 90 days of the initial allegation.

Directive 16-003 states that grievances, including those for sexual misconduct, are never referred to an employee who is the subject of the complaint.

Directive 16-003 PREA Compliant Grievance Procedure requires that grievances that allege sexual misconduct must be investigated regardless of any previously identified times limits for other types of grievances. Additionally in a case of alleged sexual misconduct, a grievant may appeal the decision of a Grievance Officer even after the 5-day limit. The client handbook also explains that grievances about sexual misconduct don’t have time limits for filing grievances or appeals. In the past 12 months, there weren’t any grievances filed that alleged sexual abuse at ABRC.

Procedure P.20.15 also states that for a good cause request by the grievance officer, the JJS Deputy Director of Facilities or the JJS director may extend, in writing, the time limit for recommending a resolution if he or she determines that an extension is necessary or in the best interest of the grievant. The grievance officer shall immediately provide a copy of the extension to the grievant.

The Client and Family Handbook provides information to residents and family members on how to file a grievance. There is a statement that “if you don’t want to make a written grievance, you can call the hotline number.” In a follow up interview, the Policy & Procedure Manager and PREA Coordinator said that the grievance policy and client handbook provide that a resident and their family or legal guardian can file a grievance. This can be done by filling out a grievance form or by calling the JJS Facility Confidential Reporting Number. Residents and their family or legal guardian can also contact the facility grievance officer, JJS Deputy Director for facilities or the JJS Director.

Policy P.20.15 - The right of grievance compliant and appeal, Section 7.4 states that clients or their families/guardians may submit grievances.

Directive 15-003 PREA Compliant Grievance Procedure also states that a grievant need not write his/her grievance or appeal, but rather can tell any employee or call the toll-free JJS Facility Confidential Reporting Number.
The policy or handbook does not provide for fellow residents, staff members, attorneys, and outside advocates to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, or permit them to file such requests on behalf of residents.

According to the client handbook, the grievance box is checked once every 24-hours on business days. Policy P.20.15 – The Right of Grievance Compliant and Appeal Section 9.3 states that the Grievance Officer, or in his or her absence, the Deputy Grievance Officer, checks each grievance box at least once every twenty-four (24) hours (Monday through Friday, excluding state holidays) and ensures each grievance box is secure and has not been tampered with.

PREA standard 115.317 e (1) states that third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, shall be permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of residents. It is not clear in the client handbook or policy that third parties can assist residents or file a grievance on behalf of a resident.

PREA standard 115.317 e (2) states that if a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process. (3) states that if the resident declines to have the request processed on his or her behalf, the agency documents the resident’s decision. The PREA Coordinator and Program & Policy Manager stated that PREA Policy 5.24 C, Section 4.2 requires that allegations of sexual misconduct are investigated even if the grievant, alleged victim, or reporter recants his/her allegation. The PREA Coordinator said that if a resident denies the allegation, it may not be investigated. However, it would be documented. In addition, residents are out in the community without staff supervision and have other ways to report sexual abuse or sexual harassment.

The Policy & Procedure Manager said that all grievances are handled within a 24-hour period, or immediately if they are submitted to the hotline during business hours. The SAP 03 Section 6.2.1 states that the Screener immediately notifies the Superintendent of the facility involved in the referral and provides the name of the client who is the subject of the abuse or neglect allegation and any other person(s) allegedly involved so that safety can be assured.

Policy 5.24 C Section 5 states: Reporting Allegations
5.1 “All employees, contractors, volunteers, and student interns must immediately report abuse and neglect, including any and all substantial risk, suspicion, information, or knowledge of sexual misconduct.”
5.2 Additionally, “all employees must immediately report and document any allegations received by third parties made verbally, in writing, or anonymously.”
5.3 “To report any allegations of sexual misconduct, employees, contractors, volunteers, and student interns must notify the Officer in Charge (OIC) immediately.”
5.4 “These are additional methods to report allegations of sexual misconduct:
Notify a JJS supervisor;
Call the toll-free JJS Facility Confidential Reporting Number;
Write a confidential letter to the PREA Reporting Office in Las Cruces, New Mexico;
Call the Statewide Central Intake (SCI) Hotline; and/or
Email and/or call the JJS PREA Coordinator.”
5.5 “If a client victim is reporting directly to an employee, that employee’s first responsibility is to keep the client safe by following the first responder protocol.”

The client handbook tells the residents and their parents that they can report problems by telling a staff member or grievance officer or by filling out a written grievance form or reporting it by calling the hotline. 115.317 (f) requires (1) The agency shall establish procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. (2) After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, the agency shall immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken, shall provide an initial response within 48 hours, and shall issue a final agency decision within 5 calendar days. The initial response and final agency decision shall document the agency’s determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance. The Program & Policy Manager said that the regular grievance process requires time
restrictions of an emergency filing per PREA statute. Therefore, in policy, no alternative/or emergency grievance provision is addressed. The PREA Coordinator and Program & Policy Manager said that PREA policy 5.24 C, Section 4.2 requires that allegations of sexual misconduct are investigated even if the grievant, alleged victim, or reporter recants his/her allegation. According to the PREA Coordinator, if a resident denies the allegation, it may not be investigated, however it still would be documented.

The hotline is not staffed 24-hours a day, and the grievance officer is not always available at all facilities, such as at ABRC. The grievance box is not checked daily and at times one staff member may be on duty. If the resident didn’t feel comfortable or safe with that staff member they would need to wait to file an emergency grievance. Therefore, the agency needs to have a way that allows a resident or staff member to report imminent sexual abuse in a manner that can immediately be reported to ensure that the client is kept safe.

**Required Corrective Action**
1. Develop a way that allows a resident to file an emergency grievance at any time that a resident is believed to be at substantial risk of imminent sexual abuse. After receiving the emergency grievance, the agency shall immediately forward the grievance to a level of review at which immediate corrective action may be taken and provide an initial response within 48 hours and issue a final agency decision within five calendar days. The initial response and final agency decision shall document the agency’s determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance.
2. The Client and Family Handbook, grievance policy and grievance form need to include language stating that emergency grievances can be filed and how to file them.
3. The grievance process should be made clear that a third party, other than a parent or legal guardian, can file a grievance on behalf of a resident. The facility may require, as a condition of processing the request, that the alleged victim agrees to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process. A parent or legal guardian of a resident may also file a grievance or appeal on behalf of the resident.

**Verified Corrective Action:**
1. On February 6, 2017, the PREA Coordinator provided documentation that the agency developed and implemented a process for residents to file an emergency grievance for risk of imminent sexual and physical abuse. Anyone can file a grievance on behalf of a resident and residents can file an emergency grievance by calling the JJS Confidential Reporting Number, informing staff or filing a grievance. This information is available on posters and in the client handbook.
2. The Client and Family Handbook includes information on filing grievances/.
3. Directive 17-001 regarding emergency grievances was developed. The policy makes it clear that third parties, parents/legal guardians, other residents, or anyone else can file an emergency grievance on behalf of a resident.

Procedure P.20.15 states that clients and their families/guardians may submit grievances in writing by placing them in the grievance box, by delivering them directly to the grievance officer, or by giving them to any JJS staff member. The grievance officer or a quality technician checks the grievance box at least once every 24 hours.

Directive 16-003 states that a grievant need not write his/her grievance or appeal, but rather can tell any employee or call the toll-free JJS facility confidential reporting number.

Residents or anyone else can also call the JJS facility confidential reporting number where if not staffed, a message can be left. It is checked at least once every 24 hours. The agency developed a process that once an emergency grievance is received, the superintendent or Officer in Charge will meet with the resident within 48 hours to provide immediate corrective action and that the resident will receive an initial response. Within 5 calendar days a final agency decision will be issued. The decision will document the agency’s determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance.

The auditor was told that there have been no grievances filed by ABRC residents alleging substantial risk of imminent sexual abuse within the past 12 months. No emergency grievances were available for review. No interviews with staff or offenders indicated that an emergency grievance had been filed.

The facility provided policy 5.24 B, which states that all employees must immediately report abuse and neglect, including any and all substantial risk, suspicion, information or knowledge of sexual misconduct.
Procedure P.20.15 states that clients, parents or legal guardians can file a grievance. Clients or families/guardians who refuse to or cannot submit a grievance in writing may make an oral grievance by contacting the Grievance Officer or the JJS Deputy Director of Facilities or JJS Director. Case managers shall be available to assist clients in filing grievances.

The pre-audit questionnaire indicated there have been no emergency grievances filed at ABRC alleging substantial risk of imminent sexual abuse within the past 12 months. Interviews with staff and offenders indicated that no offender has been disciplined for this purpose.

Policy 5.24 B, Section 10.2 states that residents who knowingly make false allegations of sexual misconduct, file grievances in bad faith, and/or engage in retaliation are subject to criminal prosecution and/or disciplinary actions. In the past 12 months, there have been no grievances filed that alleged sexual abuse that resulted in disciplinary action against residents for having filed a grievance in bad faith.

Grievance forms are provided for residents. There is also a locked box into which residents can put a grievance. The Grievance Officer and quality assurance technician are the only employees who have a key to the box. The grievance box is checked once a week.

Policy, Materials, Interviews and Other Evidence Reviewed
Pre-audit questionnaire completed by ABRC
Right of Grievance Complaint and Appeal procedure P.20.15
Directive 16-003 PREA Compliant Grievance Procedure
5.24 B, PREA Compliance – Client Education and Advocacy
5.24 C, PREA Compliance – Responding to Allegations
Interview with Grievance Officer
Interview with Bureau Chief Performance/Policy Bureau Juvenile Justice Service
ABRC Staff Acknowledgement forms
ABRC Client Acknowledgement forms
Emergency Grievance Poster
Client Grievance form
Signed Directive 17-001 regarding emergency grievances for physical and sexual abuse
Client handbook insert regarding emergency grievances

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.

Policy 5.24 B, PREA Compliant Responding to Allegations, Section 8.5 states that residents may also call or write letters to outside advocacy groups, including victim support and rape crisis organizations. Such communications are privileged and shall not be monitored. Clients are permitted to make such calls in a location that preserves confidentiality. Section 8.6 states that in addition to evaluating and supporting client victims of sexual misconduct, behavioral health clinicians evaluate client perpetrators and may recommend that they participate in offender counseling and treatment.

The pre-audit questionnaire states that the facility provides residents a client handbook and PREA brochure. These materials outline the ways to report sexual misconduct. Information on outside advocacy, including victim support and rape crisis organization information was not provided.
CYFD and the Rape Crisis Center of Central New Mexico signed a memorandum of understanding (MOU). On July 28, 2016, the Bureau Chief Performance/Policy Bureau provided verification that the posters with rape crisis advocacy lists in New Mexico and one outlining the role of sexual assault advocates were in the process of being printed. The Sexual Assault Advocacy in Detention states that advocates are provided to support the rights and wishes of the survivor. These services are confidential unless a survivor gives permission, or if there is an indication that a child or vulnerable adult is being abused or the survivor indicates he/she intends to harm him/herself. Advocacy services are provided via mail, hotline calls and in person at SANE exams.

The advocacy list outlines the specific sexual assault program for the facility and contact information. Hotline number, main office phone number, email and SANE exam location are included.

The PREA Coordinator said that the information with the rape crisis advocacy lists will be given to residents. The information will also be available on posters that will be placed in the unit, in the visiting area for families to see, and at the entrance of the facility.

Policy 5.24 B, Section 9.3 provides for an advocate to accompany and support the victim throughout the forensic medical exam and investigative interview process. The advocates provide emotional support, crisis intervention, information and referrals.

At the time of the audit, the Agency was in the process of signing a Memorandum of Understanding (MOU) with the rape crisis center. A Draft MOU Advocacy between CYFD & New Mexico Sexual Assault Coalition was provided. On July 25, 2016, the Bureau Chief Performance/Policy Bureau provided verification of the signed MOU with statewide rape crisis organizations.

Required Corrective Action:
1. Document that all current residents have received the outside victim advocacy support services information.
2. Provide information on how residents will receive this information when they enter the facility.

Verified Corrective Action:
On July 28, 2016, the Bureau Chief Performance/Policy Bureau provided verification of the rape crisis advocacy posters. The posters provide the New Mexico rape crisis advocacy addresses and phone numbers and outline the role of sexual assault advocates. The Sexual Assault Advocacy in detention states that advocates are provided to support the rights and wishes of the survivor. The services are confidential unless a survivor gives permission, or if there is an indication that a child or vulnerable adult is being abused or the survivor indicates he/she intends to harm him/herself. Advocacy services are provided via mail, hotline calls and in person at Sexual Assault Nurse Examiner (SANE) exams.

The advocacy list outlines the specific sexual assault program for the facility and contact information. Hotline, main office phone number, e-mail and SANE exam location are included.

The PREA Coordinator said that posters will be given to residents and posted in the unit and in visiting areas for families to see. They also will be provided to victims of sexual abuse/sexual assault.

Policy 5.24 B, Section 9.3 provides for an advocate to accompany and support the victim during the forensic medical exam and investigative interview process. The advocates provide emotional support, crisis intervention, referrals and other information.

P.20.11 allows opportunities to communicate with attorneys, parents, guardians in section 8.3.1, same section and information in p.20.12. The facility provides residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians in person, by phone and via written correspondence. This was confirmed in interviews with staff and residents. According to facility staff, residents are permitted to make confidential phone calls to their attorneys, parents or legal guardians. Staff members dial the number and wait outside the door while residents speak with these individuals. Residents also have opportunities to visit personally with their attorneys, parents or legal guardians.

Policy, Materials, Interviews and Other Evidence Reviewed
Pre-audit questionnaire submitted by ABRC
Interviews with residents
Interviews with staff
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.

ABRC demonstrated compliance with this standard. There are multiple methods that can be utilized for third-party reporting. The methods for reporting are provided in resident written resource information, in brochures and on posters. Policy provides visitors with information on how to report, as well as a website showing ways to report sexual misconduct. PREA posters with reporting information are available at the entrance of the facility as well as in the visiting room. During the site tour, the auditor observed brochures at the entrance of the facility. The brochures are available to visitors, family members or legal guardians who wish to make a report on behalf of a resident.

ABRC provides brochures in English and Spanish. The PREA brochure outlines the agency’s zero-tolerance policy and reporting options. A review of agency’s public website was completed. The website published the following ways to report sexual abuse or sexual harassment on behalf of offenders:
- Call the JJS PREA Coordinator 1-505-469-7700
- Email the JJS PREA Coordinator JJSPREA.Coordinator@state.nm.us
- Call the JJS confidential reporting number 1-855-563-5065

Policy, Materials, Interviews and Other Evidence Reviewed
Pre-audit questionnaire completed by ABRC
CYFD Website
PREA Brochures

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.
All CYFD staff are required to report any suspicion of alleged abuse or neglect. Policy 5.24, C, PREA Compliance – Responding to Allegations, Section 5.1 states that all employees must immediately report abuse and neglect, including any and all substantial risk, suspicion, information, or knowledge of sexual misconduct. Section 5.2 states that all employees must immediately report any allegation by third-parties made verbally, in writing, or anonymously.

In addition to policy, staff training includes the duty to report such incidents. Interviews with staff during the audit indicated they understood their duty to immediately report. New Mexico State Law 32-4-3, the New Mexico’s Children’s Code, requires every person who has information that is not prohibited as a matter of law, who knows or has a reasonable suspicion that a child is abused or neglected shall report it immediately to:
1. Law enforcement,
2. The department (CYFD)
3. A tribal law enforcement or social services agency for any Indian child residing in Indian Country.

The pre-audit questionnaire says that besides reporting to designated supervisors or officials and designated state or local services agencies, staff shall be prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified, in agency policy, to make treatment, investigation, and other security and management decisions. The pre-audit questionnaire refers Section 5.1 as requiring this information. The information was not in this section. It is contained in the Code of Conduct. On July 12, 2016, the JJS Policy & Procedure Manager provided the following to support compliance: The Code of Conduct section 2.1.1.7 Breach of Confidentiality: Integral to CYFD’s success is the protection of confidential information entrusted to us by employees, clients and other community partners. Unauthorized disclosure, misuse or mishandling of information obtained in the course of or conducted on behalf of CYFD related business activities, including unauthorized disclosure or use of protected health information is strictly prohibited. Section 2.1.1.9 Duty to Cooperate with Investigations: Allegations of violations of policies and procedures set forth by CYFD and/or state or federal law may require employees to participate as witnesses or potential witnesses in a variety of investigations. CYFD employees have a duty to cooperate in an investigation and are required to do so in good faith. During the investigative process, witnesses or potential witnesses who are interviewed are responsible to maintain confidentiality about the content of their interviews.

Policy 5.24 C states that all employees must immediately report abuse and neglect, including any and all substantial risk, suspicion, information, or knowledge of sexual misconduct.

Policy 5.24 C, PREA Compliance – Responding to Allegations Section 12.6 states that the PREA Coordinator notifies the client victim’s parent/guardian promptly of the allegation of sexual abuse. (The policy was changed from “within 14 days” to “promptly” by the Policy & Procedure Manager.) The agency determined that the PREA Coordinator is the designee of the facility superintendent. The PREA Coordinator is notified on all allegations of sexual misconduct and is responsible to initiate a PREA case file checklist and PREA incident log, confirm that law enforcement and the JJS Facility Confidential Reporting Number have been notified/called; and Notify Employee Relations Bureau (ERB) if an employee is involved. The PREA Coordinator is also responsible to monitor all allegations, including third-party and anonymous allegations, to ensure prompt, thorough, objective investigations by the appropriate investigative body. Additionally, the PREA Coordinator is required to monitor victims of sexual abuse for retaliation as well as provide them information on the status of their case. For these reasons, the agency determined that the PREA Coordinator was the appropriate designee to notify parents or legal guardians and provide on-going status updates.

The standard requires that medical and mental health practitioners shall be required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) in the standard of this section as well as to the designated state or local services agency where required by mandatory reporting laws. Residents receive medical treatment in the community.

In an interview with the mental health clinician, she stated that mental health clinicians inform residents at the initiation of services of their duty to report and the limits of confidentiality. The form is entitled “Privacy of Information Shared in Counseling/Therapy: Your Rights and My Policies.” The form instructs residents that confidentiality cannot be maintained if a resident discloses having been abused-physically, sexually or emotionally or if they harmed someone else. The form also tells the resident that their parent/guardians will also be informed.
According to the New Mexico State Children’s Code, everyone has a duty to report all information regarding abuse and neglect.

In an interview with the mental health clinician, she indicated she understood the requirements under this standard. She verified that she is required to report knowledge, information, and suspicion of sexual abuse or sexual harassment.

The facility staff reports all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports that are referred for investigation.

Policy, Materials, Interviews and Other Evidence Reviewed
Policy 5.24 C, PREA Compliance – Responding to Allegations
New Mexico 32A-4-3, Children’s Code
Policy 5.24 B, PREA Compliance – Client Education and Advocacy
Interview with mental health staff
Pre-audit questionnaire completed by ABRC
Policies and Directives updates and emails from Policy & Procedure Manager

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.

ABRC reports that there have been no situations in the past 12 months in which a resident was subject to substantial risk of imminent sexual abuse. Policy 5.24 C, PREA Compliance – Responding to Allegations Section 5.1 states that all employees must immediately report abuse and neglect, including any and all substantial risk, suspicion, information, or knowledge of sexual misconduct. Section 5.4 states that if a client victim is reporting directly to an employee, that the employee’s first responsibility is to keep the client safe by following the first responder protocols. The first responder duties must ensure the victim is safe and separated from the alleged perpetrator.

Policies sometimes state “employees” and in other places include “contractors and volunteers”. Consider reviewing all policies to determine if a contractor, volunteer or student intern needs to be added to ensure compliance with the requirement. On July 12, 2016, the JJS Policy & Procedure Manager updated policy 5.25 C, PREA Compliance – Responding to Allegations Section 5.1 and 5.3 to include “contractors, volunteers, and student interns.” Policy as well as interviews with staff confirm the requirements of this standard.

The training curriculum shows that staff is trained in this standard. Also, interviews with staff members indicated they understood the requirements for immediate action to protect residents.

Policy, Materials, Interviews and Other Evidence Reviewed
New Mexico Children’s Code
Policy 5.24 C, PREA Compliance - Responding to Allegations
Pre-audit questionnaire completed by ABRC
PREA training curriculum
Interviews with random staff
Policies and Directives updates from Policy & Procedure Manager

Standard 115.363 Reporting to other confinement facilities
Box your final determination for each of the following standards as follows:

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

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

Policy 5.24 B, Section 5.4 states that if a client alleges that he/she was sexually abused at a non-CYFD facility, the intake employee notifies the officer in charge (OIC). The OIC initiates a PHPC (which includes JJS PREA coordinator notification). The facility superintendent or deputy superintendent notifies the non-CYFD facility administrator as soon as possible, no longer than 72 hours after the allegation was received. Additionally, the superintendent notifies the PREA coordinator who documents the notification, per a PREA Case File Checklist and PREA Incident log.

On July 12, 2016, the auditor received updated policy indicating that 5.24 B Section 5.4 – 5.5 was changed to the following: 5.4 If a client alleges he/she was sexually abused at a non-CYFD facility, the intake employee notifies the OIC. The OIC initiates a PHPC (which includes JJS PREA Coordinator notification). The facility superintendent or deputy superintendent notifies the non-CYFD facility administrator as soon as possible, no longer than 72 hours after the allegation was received. Additionally, the PREA coordinator documents the notification, per a PREA Case File Checklist and PREA Incident log.

5.5 If a client alleges he/she was sexually abused at another CYFD facility, the intake employee notifies the OIC. The OIC initiates a PHPC (which includes JJS PREA Coordinator notification). The facility superintendent notifies that other CYFD facility’s superintendent as soon as possible, no longer than 72 hours after the allegation was received. Additionally, the PREA Coordinator documents the notification, per a PREA Case File Checklist and PREA Incident log.

5.6 Only when the facility Superintendent is unavailable does the Deputy Superintendent make this notification.

Interviews with the facility investigator indicated all allegations would be investigated, no matter how the information is received.

The PREA Coordinator confirmed that the Superintendent will notify the head of the facility or appropriate office of the agency where the alleged abuse occurred, and if it is one of the CYFD facilities, the Superintendent will immediately notify the New Mexico State Police and/or OIG.

Interviews with the facility investigator indicated all allegations would be investigated, no matter how the information is received.

The auditor was told that no allegations were reported at ABRC or received from another facility.

**Policy, Materials, Interviews and Other Evidence Reviewed**
- Policy 5.24 C, Responding to Allegations
- Policy 5.24 B, PREA Compliance – Client Education and Advocacy
- Completed pre-audit questionnaire by ABRC
- Interview with investigator

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

Policy 5.24 C, PREA Compliance – Responding to Allegations, outlines a process for first responders. The response covers all elements of the standard including:
- Separation of the alleged victim and abuser, preservation and protection any crime scene until appropriate steps can be taken to collect evidence.
- If the abuse occurred within a time period that still allows for the collection of physical evidence, request the alleged victim and alleged perpetrator not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.

The first responder is required to follow the same first responder duties if they are security or non-security, including notifying the officer in charge and preservation of evidence.

The facility recently issued laminated first responder cards to all staff. It is recommended that that facility develop a checklist that identifies all required steps that a first responder should take.

A review of the staff training curriculum was completed. It outlines first responder duties. Interviews with staff indicated that they know and understand their responsibility to respond.

ABRC states in the past 12 months there were no allegations of sexual abuse. First responder action for a report of sexual abuse was not required.

Policy, Materials, Interviews and Other Evidence Reviewed
Interview with random staff
PREA Coordinator
Laminated Card
Policy 5.24 C, PREA Compliance – Responding to Allegations

Standard 115.365 Coordinated response

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

**Required Corrective Action:**
1. Develop a written institutional plan/coordinated response plan that coordinates actions for a report of sexual abuse among staff first responders, medical, mental health, investigators and facility leadership.

**Verified Corrective Action:**
On September 29, 2016, the PREA Coordinator provide a written institutional plan/coordinated response plan that coordinates actions among staff first responders, medical mental health, investigators and facility leadership.

Policy, Material, Interview and Other Evidence Reviewed
Interviews with program manager, PREA Coordinator, PREA compliance manager
Pre-audit questionnaire completed by ABRC
Standard 115.366 Preservation of ability to protect residents from contact with abusers
Institutional plan/coordinated response plan

☐ 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.

A Union Contract was provided. Section B of the contract allows the employer to remove an employee from their unit for an investigation involving that employee. In interviews with the Director, Program manager and PREA Coordinator, they stated that they have the ability to remove staff sexual abusers from contact with residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted. These employees said that staff abusers will be disciplined and victims will be protected from their abusers and that the Union Contract does not prohibit them from protecting the resident.

Policy, Materials, Interviews and Other Evidence Reviewed Union Contract
Interview with Director, Program manager and PREA Coordinator
Pre-audit questionnaire completed by ABRC

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.

Policy 5.24 C, PREA Compliance - Responding to Allegations, Section 13.1 states that during the 90 days after an allegation of sexual misconduct, the PREA Coordinator must ensure that the victim, reporters, and any others who cooperated in the investigation (clients, employees, contractors, volunteers, and student interns) are protected from retaliation.

In interviews with the PREA compliance manager and PREA Coordinator, who are charged with monitoring for retaliation, they said they employ multiple protection measures. The PREA compliance manager checks to see if there have been disciplinary reports, program changes, negative performance reviews or reassignments of the victim. The PREA Coordinator has a retaliation monitoring form for victims and staff who report or cooperate in an investigation for sexual abuse or sexual harassment. The PREA compliance manager and PREA Coordinator are responsible to protect the victim, witnesses or reporters from retaliation and to monitor them for 90 days. Both said that they would continue to monitor the victim, witnesses and reporters for longer than 90 days if needed.
The auditor recommended adding to policy 5.24 C that “the agency shall employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations.” On July 12, 2016, the Policy & Procedure Manager made the following change to policy 5.24 C Section 13.2 to protect from retaliation: JJS employs multiple measures that may include housing transfers for clients, non-client contact assignment for employees, and additional support services for anyone who fears retaliation for reporting sexual misconduct and/or participating in investigations.

During the site visit, the facility PREA compliance manager and PREA Coordinator were interviewed. Both verified the process as it is outlined in policy. There weren’t any incidents that required monitoring at ABRC.

Policy 5.24 C, Section 13.2 states that periodic, documented welfare checks take place when the PREA Coordinator is monitoring a client. On July 12, 2016, the Policy & Procedure Manager made the following change to policy 5.24 C Section 13.2 to protect from retaliation, JJS employs multiple measures that may include housing transfers for clients, non-client contact assignment for employees, and additional support services for anyone who fears retaliation for reporting sexual misconduct and/or participating in investigations. Section 13.3 Client monitoring includes periodic, documented status checks. Section 13.4 The monitoring may continue after 90 days if the PREA Coordinator believes there is a continued risk of retaliation. Interviews with the PREA Coordinator confirmed that this is the policy. The PREA Coordinator states that in the past 12 months ABRC has had no incidents of retaliation by other residents or staff.

If any individual who cooperates with an investigation expresses fear of retaliation, the PREA Coordinator stated that the agency takes appropriate measures to protect the individual. Monitoring will continue beyond 90 days if necessary.

Policy, Materials, Interviews and Other Evidence Reviewed
Policy 5.24 C, PREA Compliance – Responding to Allegations
Interviews with PREA Coordinator and PREA compliance manager
Pre-audit questionnaire completed by ABRC
Active client victim retaliation monitoring form
Policies and Directives updates and emails from Policy & Procedure Manager

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.

ABRC staff stated that they do not use isolation or segregated housing to protect a resident who has reported sexual abuse. Policy P.21.18, Classification and Programs, outlines the process for confinement of residents in their rooms. If any employee, contractor or volunteer who learns that a resident is subject to sexual abuse, that person shall take immediate action to protect the resident. The facility shall assign such residents to their room and separate them from the abuser. The facility states that they do not have segregated housing.

The pre-audit questionnaire and the PREA Coordinator indicated that there were no residents who alleged being sexually abused who were held in segregated housing in the past 12 months. No residents were interviewed.

Interviews with the PREA compliance manager, PREA Coordinator and the program manager indicated they had a good understanding of the requirements of the standard and that they do not place residents in segregated housing.
Policy, Materials, Interviews and Other Evidence Reviewed
Policy P.21.18, Classification and Programs
Standard 115.342
Interviews with PREA compliance manager, PREA Coordinator and program manager
Pre-audit questionnaire completed by ABRC

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.

ABRC conducts administrative investigations for staff-on-resident and resident-on-resident non-criminal reports of abuse and sexual harassment, but does not conduct criminal investigations. Criminal investigations are conducted by the New Mexico State Police. The facility reports that in the past 12 months there have been no allegations directed at staff or residents involving criminal sexual abuse or sexual harassment.

The facility provided Policy 5.24 C, PREA Compliance Responding to Allegations, Section 10, to demonstrate compliance with the standard. Policy states that if the incident is referred for criminal prosecution, that law enforcement must conduct the investigation. All other investigations must be suspended until law enforcement releases the case for administrative processing. CYFD employees must not question the clients and employees involved or obtain statements or evidence until the release is authorized by law enforcement via the JJS Director. The New Mexico State Police conduct investigations for criminal conduct.

The Office of the Inspector General or Grievance Officer conducts administrative investigations.

During interviews, it was evident that the OIG investigator and Grievance Officer received specialized training in sexual abuse investigations involving juvenile victims. They also provided certificates to verify attendance at the PREA: Investigating sexual abuse in confinement setting training. The OIG investigator and grievance officer received specialized training in sexual abuse investigations pursuant to PREA Standard 115.34. The training curriculum was reviewed and met all provisions of PREA Standard 115.34, and rosters/certificates were provided as documentation. An interview with an OIG investigator indicated that she received and understood the training. An interview with the grievance officer indicated that she received and understood the training.

Policy 5.24 C, Section 10.1, states that if the incident is referred for criminal prosecution, law enforcement must conduct the investigation. Section 10.2 states that all other investigations must be suspended until law enforcement releases the case for administrative processing. Victim, perpetrator and witnesses are separated and the crime scene is preserved. State Police follow their procedures for criminal evidence handling to include gathering and preserving direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data, interviewing alleged victims, suspected perpetrators, and witnesses and reviewing prior complaints and reports involving the suspected perpetrator. Currently the agency is working on an MOU with New Mexico State Police requiring that they follow the requirements of the PREA standards.

A criminal allegation PREA checklist and documents were provided. They met the requirements of the standard. Interviews with the PREA Coordinator indicate an understanding of this requirement.

The agency conducts administrative investigations. Section 5.2 states that all employees must immediately report any allegation received by third parties made verbally, in writing or anonymously.
This standard also requires that when the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly and objectively for all allegations including third-party and anonymous reports. The auditor recommended adding additional language to the policy. Investigations into allegations of sexual misconduct, sexual abuse and sexual harassment shall be done promptly, thoroughly and objectively for all allegations including third-party and anonymous reports. On July 12, 2016, Policy 5.24 C section 4.2 were provided by the JJS Policy & Procedure Manager. Section 4.2 was changed to: All reports of sexual misconduct are considered credible and must be promptly, thoroughly, and objectively investigated regardless of circumstances, including the following:

- The allegation was made anonymously;
- The allegation was made by third parties;
- The employee names is no longer in custody;
- The client reporter has made false allegations previously;
- The source of the allegation recants the allegation;
- The employee receiving the allegation does not believe the allegation is true; and/or
- The client reporter has developmental and/or cognitive disabilities.

ABRC conducts administrative investigations. Policy 5.24 C, Section 10.1, states that the stand-alone policy, OIG Special Investigator and/or a Protective Service Investigator conducts an investigation of all allegations screened. Section 10.4 states that the Grievance Officer only investigate allegations and grievances that have been screened out by the PS Screener. This means that the grievance officer will only investigate resident-on-resident sexual abuse or sexual harassment allegations that are determined not to be criminal.

Since the OIG investigator conducts staff-on-resident administrative investigations, the auditor recommends adding PREA standard language to the process to ensure that investigations will determine whether staff actions or failures to act contributed to the abuse, and shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. The Policy & Procedure Manager provided the following to show that sexual abuse and sexual harassment: The OIG investigator conducts staff-on-resident administrative investigations, The Stand Alone Procedure-03 (SAP-03) section 5 “abuse” and 7 “neglect” as used in the SAP-03 shall be defined as failing to provide proper subsistence, medical, educational or other care necessary for the client’s well-being and/or failing to protect a client from foreseeable harm. Section 9.3 requires that an investigation include the following components:

1. The interview of the alleged victim(s), if available;
2. The interview of the JJS facility staff person(s), other employee(s), contractor(s), or volunteer(s) alleged to have perpetrated the abuse or neglect;
3. A review of any medical documentation concerning the alleged incident(s) to include interviewing the medical professional who conducted the examination or evaluation;
4. A review of any electronic data, in digital format, on video tape, or otherwise recorded concerning the alleged incident(s);
5. The interview of the JJS facility client, JJS facility staff person, or any other person who witnessed the alleged abuse or neglect, or who may provide additional information.
6. A review of any other pertinent material or documentation that pertains to the alleged incident(s); and
7. Protocols that oblige Department of Justice Standards for interviewing victims of sexual abuse
8. Special Investigators do not have authority to impose criminal sanctions or employee disciplinary actions; therefore, they do not cite Miranda or Garrity warnings.

The investigator said she does not terminate an investigation because the alleged abuser or victim departs or the aggressor recants the allegation. Interviews with the OIG investigator and the grievance officer indicated an understanding of this requirement.

State Police conduct criminal investigations at ABRC. The agency does not conduct compelled interviews. There were no indications that this has occurred in the past.

An interview with the OIG investigator confirmed that a resident who alleges sexual abuse is not required to submit to a polygraph examination or other truth-telling device as a condition for proceeding with an investigation.

Substantiated allegations of conduct that appear to be criminal shall be referred for prosecution. This decision is made by the New Mexico State Police. Facility staff are required to report all allegations of suspicions of sexual misconduct. ABRC states there were no sustained or any sexual abuse or sexual harassment allegations referred for prosecution since August 20, 2012.
ABRC says that they retain all written reports pertaining to administrative or criminal investigations. ABRC provided their state statute regarding retention of public records – management of electronic records stating that permanent, permanent-archival, or long-term records are on electronic media. Permanent public records are either maintained permanently by and at the custodial agency or by the custodial agency in an appropriate environmental setting. Permanent-archival records are scheduled in the custodial agency’s records retention and disposition schedule to be transferred to the SRCA permanently or transferred to the SRCA for review and final disposition. However, since the standard requires specific requirements, the auditor recommends adding to policy that the agency shall retain all written reports referenced in standard 115.317 (g) and (h). On August 9, 2016, the Policy & Procedure Manager contacted the auditor that the general counsel had a concern about the updated policy language that was present to the auditor for standard 115.317 (j). It conflicted with state statute. Therefore, Policy & Procedure Manager updated Grievances Directive 16-003 to state that the grievance officers retain all written material on each grievance alleging sexual misconduct for at least 10 years. The JJS Policy & Procedure Manager also updated SAP 03 Section 11.3 to “special investigator retains all written material on grievances alleging sexual misconduct for at least 10 years.” Policy 5.24 C, Section 14.6 states the PREA Coordinator maintains a confidential record of all follow-up communications and attempted notifications related to PREA incidents and ensures all documentation relating to PREA violations and allegations are securely and confidentially maintained for at least 10 years. The JJS Policy & Procedure Manager explained that grievance officers and the special investigator do not have access to client records or HR records so they would have no way of knowing when the juvenile client’s file is sealed or when the staff member’s employment ended. That is the reason for having the documents maintained for 10 years.

The Policy & Procedure Manager stated that resident records are sealed upon discharge from CYFD in accordance with Social Services Chapter 14 Juvenile Justice Part 22 Sealing Client Records 8.14.22.1 Children, Youth and Families Department. 8.14.22.8 Initial Notice of Sealing Eligibility:
“A. Each month, the FACTS system will review all open and closed cases to identify those cases that are closed and meet the criteria for sealing in 60 days.
B. FACTS will generate a report of clients which meet the above criteria as well as individual letters to clients who meet the criteria for sealing in 60 days.
C. The report will be posted to a centralized location for JPO offices and facilities to review and research.
D. The Office of General Counsel Records Custodian (OGC) records custodian will access the report electronically and print the letters.
E. The OGC records custodian will mail the form letters to the clients identified on the list notifying them of impending sealing and giving them the opportunity to retrieve their records prior to sealing.
F. If a client who has received a notice of sealing letter requests a copy of the their records and files, the facility or field office who holds the records shall notify the OGC records custodian of the request, and upon notification from the records custodian to proceed, shall ask the client to complete a request for information form and upon receipt of a signed form, provide the records to the client free of charge. All confidentiality provisions pursuant to the Children’s Code Section 32A-2-32, NMSA 1978 are followed prior to releasing the record to the client.
8.14.22.9 Electronic (FACTS) Records Sealing
A. Each month, the FACTS system will seal the FACTS case for clients who turned 18 over 60 days ago or were already 18 and their case has been closed for 60 days.
B. Several lists are generated for notification of sealing for the courts, district attorneys, defense attorneys and the local law enforcement/referring agencies.
C. The office of general counsel will notify all parties involved in the client’s case of the record sealing, with the exception of law enforcement/referring agencies.
[8.14.22.9 NMAC - N, 6/1/2010]”

Client records are sealed 60 days after their 18th birthday or their discharge from CYFD in accordance with Social Services Chapter 14 Juvenile Justice Part 22 Sealing Client Records. The standard states that the agency shall retain all written reports referenced in paragraph (g) and (h) of this section for as long as the alleged abuser is incarcerated, plus five years, unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention.

In an interview with the Policy & Procedure manager, she stated that the Human Resource Office can only keep employment records for three years from the date of separation from employment due to state law. The Policy & Procedure Manager provided New Mexico state statute, General Government Administration Chapter 21, Functional Records and Disposition Schedule, Part 2, Retention and Disposition of Public Records 1.21.2.230, Grievances and Investigations:
A. Category: Employee services - personnel management
B. Description: Records related to filing of grievances and investigations related to employees.
C. Retention: Destroy three years from date of separation from employment

**Required Corrective Action:**
1. The agency shall retain all written reports referenced in paragraph (g) and (h) (administrative reports and investigation including investigative facts and findings and criminal investigations) of this standard for as long as the alleged abuser is employed by the agency, plus five years.

**Verified Required Action:**
On October 11, 2016, the PREA Coordinator provided updated policy 5.24 C which now states that the PREA Coordinator will retain all investigation reports for as long as the alleged abuser is employed by CYFD plus five years, if that is longer than the 10-years record retention policy.

Policy 5.24 C, Section 4.2, states that all reports of sexual misconduct are considered credible and must be promptly investigated regardless of circumstances. The departure of the suspect or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation.

Policy, Material, Interviews and Other Evidence Reviewed
Policy 5.24 C, PREA Compliance – Responding to Allegations
Pre-audit questionnaire completed by ABRC
Specialized training certificates for OIG investigator and Grievance Officer
Interviews with OIG investigator, Grievance Officer, and PREA Coordinator
Policies and Directives updates

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.**

A stand-alone procedure for the Office of the Inspector General Investigations in Juvenile Justice Services Facilities was provided.

The standard requires that the agency impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

On July 12, 2016, the auditor received updated policy 5.24 B Section 5.4 – 5.5. It was changed to the following: 5.4 If a client alleges he/she was sexually abused at a non-CYFD facility, the intake employee notifies the OIC. The OIC initiates a PHPC (which includes JJS PREA Coordinator notification). The facility Superintendent notifies that non-CYFD facility’s administrator as soon as possible, no longer than 72 hours after the allegation was received. Additionally, the PREA Coordinator documents the notification, per a PREA Case File Checklist and PREA Incident Log.

5.5 If a client alleges he/she was sexually abused at another CYFD facility, the intake employee notifies the OIC. The OIC initiates a PHPC (which includes JJS PREA Coordinator notification). The facility Superintendent notifies that other CYFD facility’s superintendent as soon as possible, no longer than 72 hours after the allegation was received. Additionally, the PREA Coordinator documents the notification, per a PREA Case File Checklist and PREA Incident Log.

5.6 Only when the facility Superintendent is unavailable does the Deputy Superintendent make this notification.
Interviews with the facility investigator indicated all allegations would be investigated, no matter how the information is received.

During the interview with the OIG investigator, it was evident that she understood this requirement.

Policy, Materials, Interviews and Other Evidence Reviewed
Policy 5.24 C, PREA Compliant – Responding to allegations
SAP-03 Proposed Revision
Interview with OIG investigator
Pre-audit questionnaire completed by ABRC

Standard 115.373 Reporting to residents

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

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

Policy 5.24 C, Section 12.2 states that the PREA Coordinator provides the client victim with a letter reporting any criminal and/or administrative findings. Administrative findings may include the outcome of the investigation and any systemic changes JJS made to support greater safety for clients, but the letter does not include any employment action.

The offender is notified in writing whether their allegation has been determined to be substantiated, unsubstantiated, or unfounded. The PREA Coordinator confirmed that this is his practice.

The PREA Coordinator said that if their agency did not conduct the investigation, he requests the relevant information from that investigative agency in order to inform the resident. ABRC reports there were no incidents so an example was not available.

Policy 5.24 C, Section 12.3, states that regardless of whether an allegation against an employee is substantiated or unsubstantiated, the PREA Coordinator will inform the client victim whenever the following circumstances arise:

- The perpetrator is no longer working on the client's living unit;
- The perpetrator is no longer employed in JJS; and/or
- The perpetrator has been indicted and/or convicted of a sexual abuse or changes related to sexual abuse in the facility.

The auditor recommended that “the perpetrator has been indicted and/or convicted of a sexual abuse or charge related to sexual abuse in the facility” be added to the policy. On July 12, 2016, the JJS Policy & Procedure Manager provided the audit with the following changes to policy 5.24 C Section 12.3 Regardless of whether an allegation against an employee is substantiated or unsubstantiated, the PREA Coordinator will inform the client victim whenever the following circumstances arise:

- The perpetrator is no longer working on the client's living unit;
- The perpetrator is no longer employed in JJS; and/or
- The perpetrator has been indicted and/or convicted of a sexual abuse or changes related to sexual abuse in the facility.

ABRC indicates that following a resident’s allegation that he or she has been sexually abused by another resident, the agency shall subsequently inform the alleged victim whenever the agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility or the agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. Policy 5.24 C, Section 12.2 states that the outcome of the investigation and any systemic changes JJS made to support greater safety for clients, but the letter does not include any “employment action.” Regardless of whether an allegation against an employee is substantiated or unsubstantiated, the PREA Coordinator will inform the client victim whenever the following circumstances arise:
The perpetrator is no longer working on the client’s living unit;
The perpetrator is no longer employed in JJS; and/or
The perpetrator has been indicted and/or convicted of a sexual abuse or changes related to sexual abuse in the facility.

The facility provided Policy 5.24 C, Section 12.7 for verification that the agency has a policy that all notifications to residents described in this standard be documented. Section 12.7, states that the PREA Coordinator maintains a written confidential record of all follow-up communications and attempted notifications related to PREA incidents for 10 years.

ABRC said that there have been no investigations requiring notification to a client/victim in the past 12 months and therefore no notifications were made. ABRC provided an example format letter that would be sent in the event a notification was required.

Policy, Materials, Interviews and Other Evidence Reviewed
Pre-audit questionnaire completed by ABRC
Policy 5.24 C, PREA Compliance – Responding to Allegations
Interview with PREA Coordinator
Memorandum from ABRC Program manager
Form letter sample

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.

Policy 5.24 A, Section 8.1 states that JJS is obligated to report all allegations of sexual abuse to law enforcement for possible investigation and/or prosecution.

Policy 5.24 A, Section 8.2, mandates that dismissal is the presumptive disciplinary action for employees engaged in substantiated incidents of sexual abuse. Disciplinary actions for lesser violations may not always result in dismissal. Sanctions for lesser violations include consideration of the following situations: the nature and circumstances of the incidents, the employee’s disciplinary history and the sanctions previously imposed on employees with similar histories who engaged in comparable offenses.

Policy 5.24 A, Section 8.4 states that JJS reports substantiated sexual misconduct to relevant licensing agencies and oversight boards of Medical providers and BH clinicians who work in facilities.

The Policy & Procedure Manager, PREA Coordinator and Program manager confirmed that this is the practice at CYFD.

The pre-audit questionnaire completed by ABRC indicated that there have been no staff members terminated for violating sexual abuse or sexual harassment policies, or any staff disciplined for violation of sexual abuse or sexual harassment policies or reported to law enforcement or licensing boards following a termination for violating agency sexual abuse or sexual harassment policies in the past 12 months.

Policy, Materials, Interviews and Other Evidence
Reviewed Pre-audit questionnaire completed by ABRC
Policy 5.24 A, PREA Compliance – Employee Preparedness
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.

Policy 5.24 A, Section 8.5-8.7, Section 8.5 states that JJS may end services with any contractor who refuses to participate in PREA specific training or who is involved in sexual misconduct. JJS is obligated to report all allegations of sexual abuse to law enforcement. JJS also reports sexual misconduct of contractors to relevant licensing agencies and oversight boards. Section 8.6 states that JJS may end services of any volunteers who refuse to participate in PREA specific training or who are involved in sexual misconduct. JJS is obligated to report all allegations of sexual abuse to law enforcement. JJS reports sexual misconduct of volunteers to relevant volunteer agencies and oversight boards. Section 8.7 states that JJS may terminate the services of any student intern who refuses to participate in PREA specific training or who is involved in sexual misconduct. JJS is obligated to report all allegations of sexual abuse to law enforcement. JJS reports sexual misconduct of student interns to the appropriate educational institutions.

Procedure P.16.11 Contractors, Volunteers and Student Interns Section 12.1 states that each contractor, volunteer or intern shall be under the day-to-day supervision of the discipline or program area assigned, and under the overall supervision of the on-site employee with responsibility over citizen involvement. 12.3 states that each contractor, volunteer or intern shall be informed in writing that their services as a contractor, volunteer or intern are at the discretion of JJS and can be terminated at any time.

Additionally, Procedure P.16.11 Section 12.3 states that each contractor, volunteer or intern shall be informed in writing that their services as a contractor, volunteer or intern are at the discretion of JJS and can be terminated at any time. Section 12.3.2 states that the facility superintendent, Director of Faith and Community Initiatives or the department head housing the contractor, volunteer or intern each respectively reserve the right to terminate services from a contractor, volunteer or intern.

In an interview with the program manager, he said that if there was an allegation about a contractor, volunteer or intern, that individual would be removed from contact with any resident and reported to New Mexico State Police and/or JJS Protective Services.

ABRC states that in the past 12 months there were no cases that met this requirement.

Policy, Materials, Interviews and Other Evidence Reviewed

Pre-audit questionnaire completed by ABRC

Policy 5.24 A, PREA Compliance – Employee Preparedness

Interview with ABRC Program manager

Standard 115.378 Disciplinary sanctions for residents

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)
Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor’s analysis and reasoning, and the auditor’s conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Policy 5.24 B, section 10.1 states the client perpetrators of sexual misconduct are subject to criminal prosecution and/or disciplinary actions.

Also included in the documentation that ABRC provided was a policy for staff, the Facility Incident Guide – DIR Process, that outlines how staff document a JJF facility incident. Residents are provided documentation on the notification of charges and hearings results.

In the past 12 months, there was no resident-on-resident sexual abuse administrative finding that occurred at the facility.

The standard requires that residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process which follows the JJF facility incident process. The Program manager said that disciplinary sanction is commensurate with the nature and circumstances of the abuse committed, the resident’s disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories to policy and disciplinary process.

According to interviews with the ABRC program manager, PREA Coordinator and medical staff, residents are not placed in isolation as a disciplinary sanction. A resident can be confined to their room. If a resident is confined to their room, they are not denied daily large-muscle exercise or access to any legally required educational programming or special education services. ABRC states that there have been no criminal findings of guilt for resident-on-resident sexual abuse, no residents placed in isolation as a disciplinary sanction for resident-on-resident sexual abuse, or who were denied daily access to large muscle exercise, and/or legally required education programming or special education services or who were denied access to other programs and work opportunities at the facility in the past 12 months.

Policy 5.24 B, Section 10.4, states any and all sex is prohibited. Clients who engage in sex, even if participants identify it as consensual sex, are subject to criminal prosecution and/or disciplinary actions. Disciplinary action will include consideration of the following situations: the mental health and competency of the clients, the nature and circumstances of the incident, the client’s disciplinary history and the sanctions previously imposed on clients with similar histories who engaged in comparable offenses.

Policy 5.24 B, Section 8.2, states that individual treatment plans are developed with clients who are at high risk for being sexually victimized or for abusing others sexually, and specialized housing may be considered for them. In interviews with the ABRC Program manager and PREA compliance manager, they said that consideration for where or with whom a resident who was at high risk for being sexually victimized or for abusing others sexually would be placed with would be considered. Along with specialized treatment plans, examples of not housing a resident at their facility or placing the resident in their own room without a roommate might be options they would consider.

Policy 5.24 B, Section 10.1 states client perpetrators of sexual misconduct are subject to criminal prosecution and/or disciplinary actions. Section 10.4, states that in the JJF facilities, any and all sex is prohibited. Clients who engage in sex, even if participants identify it as consensual sex, are subject to criminal prosecution and/or disciplinary actions. There was no indication that residents had ever been disciplined for this offense in the past. ABRC says that it disciplines residents for sexual contact with staff only upon finding that the staff member did not consent to such contact. ABRC says that there have been no cases of this kind. However, for clarity, the agency might consider adding to policy that the agency may discipline a resident for sexual contact with staff only upon finding that the staff member did not consent to such contact.

Policy 5.24 B, Section 10.3, states that clients will not be subject to disciplinary actions if their reports of sexual abuse were made in good faith. Interviews with staff indicated they are aware of these requirements.
Residents can receive a disciplinary charge for perpetrating sexual acts against or in the presence of the individual. A multi-disciplinary team determines the consequences for the resident if found guilty of the charge by a hearing officer. The resident’s disciplinary history and mental disabilities or mental illness appear to be considered according to interviews with staff. Documentation or disciplinary procedures regarding disciplinary history, mental disability, mental illness, prior sexual abusive history or sanctions imposed for comparable offenses by other residents with similar histories were not provided.

Recommendations call for adding specific disciplinary rule categories for different types of sexual activity such as sexual acts, comments/gestures and sexual misconduct. This would also provide a way to review sanctions imposed for comparable offenses by other residents with similar histories. It will also allow the agency to deem which activity is sexual abuse. An agency can prohibit all sexual activity between residents and may discipline residents for such activity. However, it may not deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

The facility offers therapy, counseling, or other interventions designated to address and correct underlying reasons or motivations for the abuse. If the facility needed to provide a resident with therapy or counseling for sexually aggressive/abusive behavior, it would be discussed with the multi-disciplinary team and incorporated into the resident’s treatment plan. The agency does not require participation in such intervention as a condition of access to general programming or education.

Policy, Materials, Interviews and Other Evidence Reviewed
Policy 5.24 B, PREA Compliant – Client Education and Advocacy
Facility DIR Guide
Pre-audit questionnaire completed by ABRC
Interviews with program manager, PREA compliance manager, PREA Coordinator and medical staff

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.

The facility stated that no residents disclosed prior victimization during screening. As a result, no residents were offered consultations with a medical or mental health practitioner. There were no examples for the auditor to review.

P.4.12, Client Care and Treatment, Section 12.4, states that qualified health care professionals conduct the initial medical screening/examination. Section 20 states that new and transferring clients receive a comprehensive intake behavioral health screening performed by qualified behavioral health care professionals upon arrival at the facility.

In interviews with the medical administrator and behavior health clinician, they said that if a resident has experienced prior sexual victimization, the resident is offered medical and/or mental health treatment. If a resident has previously perpetrated sexual abuse, the resident is offered a follow up meeting with mental health. The information is used to inform treatment plan, security and management decisions.

In interviews with the Program manager and PREA compliance manager, they stated that this information is used in housing, bed and program assignment decisions.

The PREA Coordinator said that there were no reports that a resident previously perpetrated sexual abuse, where it occurred in an institutional setting or in the community that required staff to ensure that a resident was offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening at ABRC.
New Mexico State Children’s Code states (1) transfer legal custody to the department, an agency responsible for the care and rehabilitation of delinquent children, which shall receive the child at a facility designated by the secretary of the department as a juvenile reception facility. The department shall thereafter determine the appropriate placement, supervision and rehabilitation program for the child.

According to the New Mexico State Children’s Code, everyone has a duty to report all information regarding abuse and neglect. The Protective Services worker will “screen in” or “screen out” the call based upon their criteria. Protective Services regards all residents in the legal custody of the CYFD to be subject to this statute even when that resident is over 18.

P.4.12 Client Care and Treatment Section 9.3.3.2 states that when the client is under 14, or with the client consent the office in charge (OIC) notifies the client’s parent/guardian/custodian once the client returns or is admitted to the hospital. The OIC may request a medical or behavioral health staff member to make the notification. Section 9.4.4 states that if the victim is a client, the staff notifies the superintendent and the client’s family if the client is under 18. Client consent should be obtained whenever possible if the client is over 14 years of age. PREA standard 115.381 (d) requires that medical and mental health practitioners shall obtain informed consent from residents before reporting information about prior sexual victimization that not occur in an institutional setting, unless the resident is under the age of 18.

The auditor was told that Protective Services wants to ensure that prior abuse has been officially investigated and ensure that no other minor children in the home might be at risk. However, according to an interview with the Bureau Chief, consent is obtained from the resident prior to notifying parents or guardians regarding prior victimization. This is based upon New Mexico state law where the age of consent is 14. New Mexico State Children’s Code 32A-6A-15. Consent for services; children fourteen years of age or older (2007) states “A. A child fourteen years of age or older is presumed to have capacity to consent to treatment without consent of the child's legal custodian, including consent for individual psychotherapy, group psychotherapy, guidance counseling, case management, behavioral therapy, family therapy, counseling, substance abuse treatment or other forms of verbal treatment that do not include aversive interventions. Nothing in this section shall be interpreted to provide a child fourteen years of age or older with independent consent rights for the purposes of the provision of special education and related services as set forth in federal law.” Statute 24-7A-6.2 Consent to Health Care for certain Minors Fourteen Years of Age or Older states “A. An unemancipated minor fourteen years of age or older who has capacity to consent may give consent for medically necessary health care; provided that the minor is:
1) living apart from the minor’s parents or legal guardian; or
2) the parent of a child.
B. For purposes of this section, “medically necessary health care” means clinical and rehabilitative, physical, mental or behavioral health services that are:
1) essential to prevent, diagnose or treat medical conditions or that are essential to enable an unemancipated minor to attain, maintain or regain functional capacity;
2) delivered in the amount and setting with the duration and scope that is clinically appropriate to the specific physical, mental and behavioral health-care needs of the minor;
3) provided within professionally accepted standards of practice and national guidelines; and
4) required to meet the physical, mental and behavioral health needs of the minor, but not primarily required for convenience of the minor, health-care provider or payer.”

Interviews with medical and mental health staff indicated that understand the requirement to report.

Ensure that policy is consistent with New Mexico state law.

Policy, Materials, Interviews and Other Evidence Reviewed
Policy 5.24 C, PREA Compliant – Responding to allegations
Interviews with medical and mental health staff
Interviews with Program manager and PREA compliance manager
Interview with Bureau Chief Performance/Policy Bureau
Pre-audit questionnaire completed by ABRC
P-4.12 Client care and treatment
Vulnerability Samples
Medical Behavioral Health Secondary Material
New Mexico State Statute

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.

ABRC reports that there were no resident victims of sexual abuse in the past 12 months. There were no medical records for this auditor to review for resident victims. Agency policy 5.24 B, PREA compliant client education and advocacy, requires that Section 8.3 states that upon receiving a notification of a sexual abuse allegation, the compliance manager assigns a behavioral health clinician as an in-house advocate to the client. Section 9.1 states that onsite medical employees offer client victims information and access to pregnancy tests, emergency contraceptives, prophylaxis medications, pregnancy related medical services and tests and treatment for sexually transmitted diseases. Services are provided even if the victim names the abuses and/or cooperates with the investigation. Section 9.2, A client requesting a SANE exam, is transported to a clinic and provided services and advocacy at no cost.

During interviews, medical and mental health staff confirmed that residents receive timely, unimpeded access to emergency medical treatment and crisis intervention. Residents receive emergency contraceptives and are not charged for them and are sent to SANE for medical treatment and services.

In an interview with the medical administrator, she said that residents would be sent to SANE within an hour of a sexual assault report. Upon return from SANE, medical would follow up with medical treatment, if needed. Due to the facility being a reintegration center, follow-up and treatment plans would be out in the community.

Policy, practice and interviews with medical and mental health staff demonstrate compliance with this standard. Policy, Materials, Interviews and Other Evidence Reviewed
Policy 5.24 B PREA, Compliance – Client Education and Advocacy
Pre-audit questionnaire completed by the ABRC
Interviews with the medical administrator and mental health staff

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.

There has been no victims of sexual abuse in the past 12 months at ABRC. Therefore, the auditor was not able to interview any resident victims or review any corresponding documentation of practice.

ABRC does not have female residents and pregnancy related services required in this standard are not applicable.
Agency policy requires that the resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment. Crisis intervention is currently being developed for residents. However, victims of sexual abuse that are brought to Albuquerque SANE where they are provided forensic medical exams and an advocate is available. According to their website the following services are available:

- Victims of sexual assault and domestic violence are provided care in an empowering setting that addresses emotional and medical needs. All care is comprehensive, timely and patient-centered. Services are always confidential, free and available 24 hours a day. In most cases, reporting to law enforcement is voluntary.
- The nurse examiner will perform the medical/forensic exam in a caring, respectful and supportive manner. An advocate is available to provide other support and information to the patient and their family and friends during the exam process.
- After the exam the patient can shower in a private area and will be provided a new change of clothing, if they choose to have their clothing held as evidence.

Services offered to victims:
- Triage and Intake
- Medical/Forensic History
- Medical Exam – head to toe
- Forensic Exam (sexual assault evidence kit)
- Forensic Photography
- Pregnancy Prevention
- Sexually Transmitted Infection (STI) Prevention
- Referrals
- Follow-up services
- Testimony

Collaborative to provided advocacy services during the exam. Types of services provided to the victim are:
- • Triage and intake
- • Medical forensic history
- • Medical exam
- • Forensic exam
- • Pregnancy prevention
- • Sexually transmitted infection prevention
- • Referrals
- • Follow-up services

During interviews with the medical administrator, nurse and mental health staff, program manager and PREA compliance manager, they said that residents would be sent to Albuquerque SANE. Upon return from SANE, medical and mental health would follow up with medical treatment, if needed. Due to the facility being a reintegration center, follow-up and treatment plans would be in the community.

Mental health would evaluate a resident-on-resident abuser if the resident remained within the facility or transferred to another facility within the agency. According to interviews with staff, the resident would probably be removed from CYFD.

Agency policy 5.24 B, PREA compliant client education and advocacy, requires that Section 8.3 states that upon receiving a notification of a sexual abuse allegation, the compliance manager assigns a behavioral health clinician as an in-house advocate to the client. Section 9.1 states that onsite medical employees offer client victims information and access to pregnancy tests, emergency contraceptives, prophylaxis medications, pregnancy related medical services and tests and treatment for sexually transmitted diseases.

Medical staff confirmed that residents would be provided prophylaxis medications and treatment for sexually transmitted diseases. ABRC has male residents and standards (d) and (e) are not applicable.
Information provided by PREA Coordinator
Albuquerque SANE collaborative website

Standard 115.386 Sexual abuse incident reviews

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

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

The facility reports that there have been no criminal or administrative investigations within the past 12 months. Staff involved in an incident review are the program manager, program supervisor/PREA compliance manager, behavioral health/mental health staff, PREA Coordinator and possibly a case worker.

There were no sexual abuse incidents to review. However, interviews with members of the incident review team showed a good understanding of the requirements for the reviews.

Policy 5.24 C, Section 11 states that the PREA Coordinator must debrief any PREA violation and all allegations of sexual misconduct to consider and initiate follow-up actions, review the evidence against the employee, and potentially initiate an Employee Relations Bureau (ERB) investigation. The debriefing would identify training needs or consider physical plant or monitoring technology modifications that might better protect residents from sexual misconduct.

During interviews it was stated that incident reviews would be used as a learning tool to determine anything that went wrong during the process and how to prevent it from happening again. Changes to procedures or physical areas would also be made, if needed, to keep employees and residents safe and protect them from sexual misconduct.

The agency’s PREA policies do not contain provisions establishing a formalized sexual abuse incident review team or process. It is recommended that the process be added to policy. A formalized sexual abuse incident review process with timeframes should be developed in policy to support practice. However, after review of the form and interviews with the PREA Coordinator, Superintendent and PREA Compliance Manager, the auditor determined that the facility is in compliance with the standard. On July 29, 2016, the Policy & Procedure Manager provided the following update to Policy 5.24 C, Section 11.

Policy 5.24 C, Section 11 states that the PREA Coordinator must debrief any PREA violation and all allegations of sexual misconduct to consider and initiate follow-up actions, review the evidence against the employee, and potentially initiate an Employee Relations Bureau (ERB) investigation. The debriefing would identify training needs or consider physical plant or monitoring technology modifications that might better protect residents from sexual misconduct.

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11.1 states that “after OIG conducts an investigation of a screened-in allegation, the investigator conducts an exit staffing. In the staffing, a representative from the JJS Director’s Office, the PREA Coordinator, and the Office of Quality Assurance (OQA) Director are present to consider and initiate follow-up actions subsequent to the OIG investigation:
• Review the evidence against the employee, and potentially initiate an ERB investigation;
• Alert the PREA team of appropriate debriefing and training needs for involved employees at the facility level;
• Consider any physical plant or monitoring technology modifications that might better protect clients from sexual misconduct; and
• Recommend potential procedure modifications to the P&P Manager that might better protect clients from sexual misconduct.”

11.2 states that the “facility Superintendent or Program Manager and the PREA Manager must debrief all PREA violations and allegations of sexual misconduct (both substantiated and unsubstantiated). The debriefing team includes youth care specialists, medical providers, and BH clinicians. The team considers and initiates follow-up actions:
Assesses the motivation and possible causes of the incident, and considers these factors: race; ethnicity; gender identity; LGBTQI (lesbian, gay, bisexual, transgender, questioning, or intersex) identification, status, or perceived status; gang affiliation; or group dynamics at the facility
- Alert the PREA team of appropriate debriefing and training needs for involved employees at the facility level;
- Consider any physical plant or monitoring technology modifications that might better protect clients from sexual misconduct;
- Review staffing patterns and make appropriate adjustments to keep employees and clients safe;
- Recommend potential procedure modifications to the P&P Manager that might better protect clients from sexual misconduct;
- Prepare a report with recommendations for the facility Superintendent, the PREA Coordinator, and JJS administration.

Policy, Materials, Interviews and Other Evidence Reviewed
Pre-audit questionnaire completed by ABRC
Interviews with PREA Coordinator and program manager
Policy 5.24 C, PREA Compliance-Responding to Allegations

Standard 115.387 Data collection

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

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

The agency 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 agency aggregated the data for 2015 and prepared a report. The policy and practice requires the collection of the data. The PREA Management Analyst compiles all facility PREA statistics from a variety of sources. The statistics come from a variety of sources, including:
- PREA incident checklist,
- PS Screener documentation,
- PREA reporting log from the hearing officers
- Grievance tracking log from the GOS
- Search Logs
- Unannounced rounds logs
- Serious Incident Reports (SIRs)
- Disciplinary Incident Reports (DIRs)

The PREA Coordinator is responsible to compile all agency PREA statistics. The PREA Coordinator stated that this is the first annual report required for this standard.

ABRC provided a copy of the 2015 Survey of Sexual Victimization: San Juan Juvenile Detention Center. The agency has the information posted on the website.

A review of the 2014 Survey of Sexual Victimization (SSV) determined compliance and that the agency provides all data to the Department of Justice.

Policy, Materials, Interviews and Other Evidence Reviewed Policy 8.14.23
Definitions for data collection
Interview with PREA Coordinator
2016 PREA investigation log
PREA grant for data collection tool
Pre-audit questionnaire completed by ABRC
2014 Survey of Sexual Victimization
Review of San Juan Juvenile Detention Center 2015 SSV survey

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.

CYFD’s PREA Coordinator said that the first annual report was produced May 2016. Interviews with the CYFD’s director and the PREA Coordinator demonstrate compliance with this standard. The auditor verified that the 2015 PREA Annual Report was posted on the agency’s website. Policy 5.24 C, PREA Compliance Responding to allegations Section 14 requires the PREA Coordinator to report aggregate data as well as ensure that the agency’s PREA statistics and compliance documentation are compiled and published annually.

Additionally, in February 2014, the agency hired the Performance-Based Standards Learning Institute to provide standards to identify, monitor, and improve conditions and treatment services provided to incarcerated youth using national level standards and outcome measures. Data that supports the agency’s zero-tolerance for sexual misconduct is collected twice a year through a confidential client survey.

Policy, Materials, Interviews and Other Evidence Reviewed
Annual Report
Interview with CYFD Director and PREA Coordinator
Pre-audit questionnaire completed by ABRC
Information obtained from the Bureau Chief Performance/Policy

Standard 115.389 Data storage, publication, and destruction

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

☐ Does Not Meet Standard (requires corrective action)

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

The CYFD PREA Coordinator reports that the first annual report was produced and posted on its website in May 2016. Interviews with agency director and the PREA Coordinator demonstrate compliance with the standards. State law addresses required records retention periods. An annual report for CYFD can be viewed on the agency’s website https://cyfd.org/docs/2015_PREA_Annual_Report.pdf. The annual reports does not include any personal identifiers.
The agency provides aggregated sexual abuse data from the private facility it contracts with on the CYFD website. The auditor confirmed that the private facility, San Juan Juvenile Detention Center, with whom it contracts for the confinement of its residents, aggregated sexual abuse data was on the CYFD-JJS website. The 2015 Survey of Sexual Victimization for San Juan Juvenile Detention Center made available to the public on CYFD-JJS PREA website https://cyfd.org/facilities/prison-rape-elimination-act-prea/ under the Aggregated Data section.

On July 29, 2016, the Policy & Procedure Manager provided the following updated to Policy 5.24 C, Section 14.

14 Data Collection and Reports
14.1 The PREA Management Analyst compiles all facility PREA statistics from a variety of sources, including:
- PS Screener documentation;
- PREA Reporting Log from the Hearing Officers;
- Grievance Tracking Log from the GOs;
- Search Logs;
- Unannounced Rounds Logs;
- Serious Incident Reports (SIRs); and
- Disciplinary Incident Reports (DIRs).

14.2 The PREA Coordinator compiles all agency PREA statistics from a variety of sources, including:
- OIG exit staffing information;
- Office of Quality Assurance (OQA) Quarterly Report; and
- Reports generated from the Case Management System (CMS).

14.3 The PREA Coordinator reports the aggregate data (with personal identifiers removed) in several ways, including: CYFD website; Performance-based Standards (PbS) reporting forms; and Department of Justice (DOJ) requests.

14.4 The PREA Coordinator ensures that the agency’s PREA statistics and compliance documentation are compiled and published annually.

14.5 In addition to publishing the agency’s PREA statistics and compliance documentation, the PREA Coordinator publishes relevant contracts, agreements, and Memoranda of Understanding (MOUs) with rape crisis centers, SANE clinics, law enforcement, and other community partners that ensure PREA compliance, especially as they relate to investigations.

14.6 The PREA Coordinator maintains a confidential record of all follow-up communications and attempted notifications related to PREA incidents and ensures all documentation relating to PREA violations and allegations are securely and confidentially maintained for at least 10 years.

The CYFD ensures that uniform data for every allegation of sexual misconduct at any of the facilities are collected and securely retained. The agency makes aggregated sexual abuse data from its facility and private facilities available to the public in the annual report which available on the agency website.

Aggregated sexual abuse data from the private facility the agency contracts with is available on the website.

Policy, Materials, Interviews and Other Evidence Reviewed
1.13.3 New Mexico Records Retention and Security
Pre-audit questionnaire completed by ABRC
Interview with PREA Coordinator and Agency director
Policies and Directives updates and emails and interview with Policy & Procedure Manager

AUDITOR CERTIFICATION:

AUDITOR CERTIFICATION
I certify that:
☒ The contents of this report are accurate to the best of my knowledge.

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

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

La Cole Archuleta  February 10, 2017