

**PREA AUDIT REPORT    INTERIM    FINAL**  
**JUVENILE FACILITIES**

**Date of report:** 08-09-2017

<b>Auditor Information</b>			
<b>Auditor name:</b> David "Will" Weir			
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<b>Email:</b> <a href="mailto:will@preaamerica.com">will@preaamerica.com</a>			
<b>Telephone number:</b> 405-945-1951			
<b>Date of facility visit:</b> 06-30-2017			
<b>Facility Information</b>			
<b>Facility name:</b> Eagle Nest Reintegration Center (ENRC)			
<b>Facility physical address:</b> 28783 US HWY 64; Eagle Nest, NM 87718			
<b>Facility mailing address:</b> <i>(if different from above)</i> P.O. Box 317; Eagle Nest, NM 87718			
<b>Facility telephone number:</b> (575) 377-6911			
<b>The facility is:</b>	<input type="checkbox"/> Federal	<input checked="" type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input type="checkbox"/> Private not for profit		
<b>Facility type:</b>	<input checked="" type="checkbox"/> Correctional	<input type="checkbox"/> Detention	<input type="checkbox"/> Other
<b>Name of facility's Chief Executive Officer:</b> Frank Cortez, Program Manager			
<b>Number of staff assigned to the facility in the last 12 months:</b> 15			
<b>Designed facility capacity:</b> 12			
<b>Current population of facility:</b> 8			
<b>Facility security levels/inmate custody levels:</b> low			
<b>Age range of the population:</b> 16-21			
<b>Name of PREA Compliance Manager:</b> Genovevo Carrillo		<b>Title:</b> YCS Supervisor	
<b>Email address:</b> genovevo.carrillo@state.nm.us		<b>Telephone number:</b> (575) 377-2690	
<b>Agency Information</b>			
<b>Name of agency:</b> Juvenile Justice Services			
<b>Governing authority or parent agency:</b> <i>(if applicable)</i> Children, Youth and Families Department			
<b>Physical address:</b> 1120 Paseo De Peralta			
<b>Mailing address:</b> <i>(if different from above)</i> P.O. Drawer 5160, Santa Fe, NM 87501			
<b>Telephone number:</b> (505) 827-7629			
<b>Agency Chief Executive Officer</b>			
<b>Name:</b> Tamera Marcantel		<b>Title:</b> Director, Juvenile Justice Services	
<b>Email address:</b> Tamera.Marcantel@state.nm.us		<b>Telephone number:</b> (505) 216-8593	
<b>Agency-Wide PREA Coordinator</b>			
<b>Name:</b> Eugene Brewster		<b>Title:</b> PREA Coordinator	
<b>Email address:</b> Eugene.Brewster@state.nm.us		<b>Telephone number:</b> (505) 252-8020	

## AUDIT FINDINGS

### NARRATIVE

PREA America LLC was retained on April 12, 2016 to perform the Eagle Nest Reintegration Center (ENRC) PREA Audit. The State of New Mexico Children Youth and Families Department Juvenile Justice Services Bureau Chief of Performance and Policy Greg Nelson, CYFD Contract Specialist Gabe Salazar, and CYFD JJS PREA Coordinator Eugene Brewster facilitated the process. Notices of the on-site audit went up by May 17<sup>th</sup> and the Pre-Audit Questionnaire with supporting documentation was received by the audit team May 26<sup>th</sup>. There was a pre-audit conference held by telephone on June 19, 2017 after the auditor had reviewed the materials sent. CYFD agency officials Eugene Brewster, Valerie Valverde and Greg Nelson were in attendance with ENRC officials Frank Cortez and Genovevo Carrillo and the audit team. Questions were answered regarding the documentation that had been sent, and the audit itinerary was discussed. Additional communication occurred through emails and phone calls.

The on-site audit was conducted as planned June 30<sup>th</sup>. PREA America Auditor Will Weir and Project Manager Tom Kovach arrived at 7 that morning. The first order of business was to interview overnight staff who needed to leave. Then the audit team met with Agency PREA Coordinator Eugene Brewster, ENRC Program Manager Frank Cortez, Reintegration Superintendent Adam Cordova, ENRC YCS Supervisor Genovevo Carrillo, and PREA Management Analyst Valerie Valverde for an introductory conference. The audit team were provided a tour of the facility, then they returned to interviews and document reviews. The audit team interviewed 8 facility staff and administrators (includes 5 specialized staff: most supervising staff double as specialized staff), and also PREA Coordinator Eugene Brewster, CYFD JJS Reintegration Superintendent Adam Cordova, CYFD JJS PREA Management Analyst Valerie Valverde, CYFD Juvenile Justice Services Director Tamera Marcantel (this interview by phone), CYFD Inspector General Special Investigator Wendy Johnson, CYFD Contract Manager Maria Sanchez (by phone), CYFD Human Resources Director Lisa M. Fitting (by phone), and CYFD JJS Bureau Chief of Performance and Policy Greg Nelson. All 8 facility residents were interviewed. The audit team was impressed by the professionalism of the staff, the organizational skills of the administration, and the positive morale of the residents.

Agency PREA Coordinator Eugene Brewster, ENRC Program Manager Frank Cortez, CYFD JJS Reintegration Superintendent Adam Cordova, ENRC YCS Supervisor Genovevo Carrillo, CYFD JJS PREA Management Analyst Valerie Valverde, ENRC Behavioral Health Coordinator Vickie Goguen, and CYFD JJS Bureau Chief of Performance and Policy Greg Nelson attended an exit conference with the audit team immediately after the onsite audit. The topics of the exit conference covered the ongoing challenges any organization faces in keeping people trained regarding something that typically a rare experience. They are going forward with their ongoing refresher trainings, having an extra one this year regarding first responder duties and coordinated response. There are ongoing efforts to word things better and to constantly improve avenues of communication. The Stand Alone Procedure (SAP) JJS Facility Confidential Reporting line available to all residents and employees and the CYFD Office of the Secretary, the Office of Inspector General, and even the Protective Services Screeners operating the CYFD Protective Services hotline, has been mentioned a number of times as their communication and documentation work horse, providing tracking, urgency, and resolution of any number of potential threats, grievances, and problems throughout the agency. That system, combined with the 24/7 hands on open door approach of ENRC leadership, with most staff having decades of experience, and a supervisor living on the grounds, combined with an Eagle Next community that welcomes ENRC residents and quickly hires them in various area businesses, makes the facility seem like a truly supported community, ready and capable to handle what it needs to handle as they provide the nuts and bolts of day to day effective reintegration services. Interviews indicate full anticipation that sexual abuse and harassment will be rare but handled appropriately and decisively according to protocols in place. No applicable PREA standard has been overlooked or treated like it is only a formality. They indicate a natural inclination to follow the standards because it is the best way to safely operate a facility.

Documentation reviewed includes: Pre Audit Questionnaire; website; Organizational Charts; Contract with San Juan County; Staffing Plan, with review, assessment and documents related to Staffing Plan Development Process; documentation of unannounced rounds; Guidance in Cross-Gender and Transgender Pat Searches (by The Moss Group, Inc.) to be used in training; CYFD JJS Secure Facilities Client and Family Handbook; Memo from Eugene Brewster regarding residents with disabilities and residents who are limited English proficient; Interpretation Services protocols; CYFD JJS Facility Medical & Behavioral Health Services Special Needs and Services Procedure; Staff PREA training curriculum; New Mexico Interagency Behavioral Health Service Requirements and Utilization Guidelines; State of New Mexico Department of Public Safety Evidence/Property Handling Policy; CYFD JJS Advocacy MOU's with La Pinon Sexual Assault Recovery Services, Alternatives to Violence, Arise Sexual Assault Services and Rape Crisis Center of Central New Mexico; Letter from State Police Training Academy Captain Dina L. Romero; Verification of ENRC staff completing PREA training; CYFD PREA Quarterly Newsletters; CYFD PREA Volunteer and Contractor Training and signed acknowledgements by volunteers and contractors; Verification of background checks being completed on employees, volunteers and contractors; Verification of completion of Sexual Abuse in a Confinement Setting Investigator Training; Verification of Completion of PREA training entitled PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting; CYFD JJS Vulnerability Assessment Instrument: Risk of Victimization and/or Sexually Aggressive Behavior/Violent Behavior; CYFD JJS Classification and Programs Procedure; JJS Policies and Procedures regarding Room Confinement; JJS Facility Medical and Behavioral Health Services Health Promotion and Disease Prevention Procedure; Third Party Reporting Form; PREA posters and other materials in English and Spanish; Interagency Agreement for PREA Reporting between CYFD and the New Mexico Corrections Department (NMCD); MOU between CYFD and the Consulate General of Mexico; CYFD JJS Right of

Grievance Complaint and Appeal Procedures; PREA Training Acknowledgement for Clients; Sexual Assault Advocacy in Detention and New Mexico Advocacy List; CYFD JJS Client Right to Telephone Use Procedure; CYFD JJS Client Right to Correspondence Procedure; CYFD JJS Human Resources Code of Conduct; New Mexico law: NM Stat 32A-4-3; New Mexico Age of Consent Laws 2017; Shift Bidding in Agreement Between the State of New Mexico and AFSCME Council 18; CYFD Office of the Secretary Stand-Alone Procedure; Office of the Inspector General Investigations in Juvenile Justice Services Facilities; instructions regarding documenting facility incidents; Confidentiality of Client Reports policy and definitions; Statewide PREA Investigation Log; PREA Grant for Data Collection Tool; Records Retention and Security policy; Facility Schematic; PREA Coordinator Job Description; Behavioral Health documentation, Coordinated Response Protocol; resident PREA education acknowledgements; forms and referrals; rosters of staff and residents; PREA Policies and Procedures and Population Reports.

## DESCRIPTION OF FACILITY CHARACTERISTICS

CYFD Juvenile Justice Services/Facilities (JJS) has adopted the Cambiar New Mexico model which 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 healthy adulthood. JJS protects them from harm, and continues to provide for public safety. Major initiatives include:

Developing smaller, secure regional facilities 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 who receive training that provides them with security and therapeutic skill sets

Providing rich programming including education, vocational, behavioral health, medical and other services

Perhaps the jewel in this crown of reintegration facilities is the Eagle Nest Reintegration Center. The old hunting lodge on state park property is on less than three acres nestled in the woods a few miles from its namesake town. Access off the state highway is a dirt and gravel road which goes far enough to make you think you are lost. Perhaps this is one of the ingredients to the success of this program. The remote location in an idyllic wooded area has a natural stream, waterfall and small pond. There are fish in the pond and wildlife roams the area. The old log lodge was expanded to include a 12 bed dorm. The bathroom and laundry is off to the side. A library and class room is opposite the staff area and hall that connects to the main lodge with a large group/day room. There is a wing up the stairs that includes offices and a kitchen. Further up the hill is a house occupied by a senior staff member who can help cover when inclement weather closes the mountain roads.

## **SUMMARY OF AUDIT FINDINGS**

Eagle Nest Reintegration Center, operated by the Juvenile Services Division of the New Mexico Children, Youth and Families Department, received its on-site PREA audit on June 30, 2017. DOJ Certified PREA Auditor David “Will” Weir has verified compliance through interviews and a review of documents and found the facility to be fully compliant with all applicable PREA Standards based on their successful completion of the PREA Audit process. The facility exceeded standards in two areas.

Number of standards exceeded: 2

Number of standards met: 38

Number of standards not met: 0

Number of standards not applicable: 1

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

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

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

The facility has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment, and a policy outlining how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment and it includes sanctions for those found to have participated in prohibited behaviors. The policy includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents. According to interviews with residents and staff, there is a commitment to the zero tolerance policy and the safety of the residents. The agency employs and designates an upper-level, agency-wide PREA coordinator who has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in the facility. PREA Coordinator Eugene Brewster reports to Greg Nelson, Bureau Chief of Performance and Policy. There are seven Compliance Managers who report to Mr. Brewster. ENRC PREA Compliance Manager Genovevo Carrillo is the Deputy Superintendent of ENRC and answers directly to the JPTC Superintendent.

### 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.**

NA. The facility reports no contracts with other entities for the confinement of its residents. However, the agency does have a contract with San Juan County Juvenile Services and complies with this PREA standard by requiring that facility to be compliant and monitoring that compliance.

### Standard 115.313 Supervision and monitoring

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

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CYFD develops, documents, and makes its best efforts to comply with a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against abuse. In calculating adequate staffing levels and determining the need for video monitoring, it takes into consideration: Generally accepted juvenile detention and residential practices; Any judicial findings of inadequacy; Any findings of inadequacy from Federal investigative agencies; Any findings of inadequacy from internal or external oversight bodies; All components of the facility's physical plant (including "blind spots" or areas where staff or residents may be isolated); The composition of the resident population; The number and placement of supervisory staff; Institution programs occurring on a particular shift; Any applicable State or local laws, regulations, or standards; The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and Any other relevant factors. The average daily number of residents is 9. The staffing plan was based on 12. At least once every year the agency, in collaboration with the PREA Coordinator, reviews the staffing plan to see whether adjustments are needed to: the staffing plan; prevailing staffing patterns; the deployment of monitoring technology; or the allocation of agency or facility resources to commit to the staffing plan to ensure compliance with the staffing plan. Staffing plans, policies, and reviews were provided to the audit team for review. The facility requires that intermediate-level or higher-level staff conduct unannounced rounds to identify and deter staff sexual abuse and sexual harassment. Documentation of these rounds were reviewed by the audit team.

#### **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.**

No cross gender searches of any kind is permitted by CYFD, absent exigent circumstances which have to be documented. The facility does not conduct any kind of cross-gender searches of residents except in exigent circumstances (which are fully documented and justified) or when performed by medical practitioners. According to interviews and documentation provided, none of these have been conducted in the past year. Residents shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. Staff of the opposite gender announce their presence when entering a resident housing unit. Staff are forbidden from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner. The agency has trained security staff in how to conduct cross-gender pat-down searches in exigent circumstances, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. Interviews with residents indicated no worries about any part of this standard being violated.

#### **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.**

PREA Coordinator Eugene Brewster states in a memo that ENRC does not currently house any clients who are disabled or who are limited in English proficiency. He assures that, "In the event we had a client with a disability we would make the appropriate accommodations to assist them in understanding PREA." He provides a list of interpreter services with instructions and protocols for utilizing the services, including for emergencies. Also provided are the CYFD JJS policies (applying to all facilities) for providing close supervision when needed by residents with developmental disabilities and serious mental health needs. These policies address identification of needs, and the provision of appropriate services, during intake and throughout the time the resident is in care. Also specifically addressed is the provision of services for victims of sexual assault. 14.9.1-3 States: "The medical and psychological trauma of a sexual assault is minimized by prompt and appropriate health and behavioral health intervention. Victims of sexual assault are referred to the Sexual Assault Nurse Examiner (SANE) program for treatment and the gathering of evidence. Follow-up counseling at a community rape crisis center will be considered as part of the long-term treatment plan."

CYFD has established procedures to provide disabled residents, and residents with limited English proficiency, equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Agency policy prohibits use of resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under § 115.364, or the investigation of the resident's allegations. In the past 12 months, there have been no instances where resident interpreters, readers, or other types of resident assistants have been used and it was not the case that an extended delay in obtaining another interpreter could compromise the resident's safety, the performance of first-response duties under § 115.364, or the investigation of the resident's allegations. Staff and residents indicate the agency will go the extra mile to assist anyone to understand what they need to understand in order to be safe and exercise their rights.

#### **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.**

CYFD policy prohibits hiring or promoting anyone who may have contact with residents, and prohibits enlisting the services of any contractor who may have contact with residents, who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section. The Agency policy requires the consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. Policy requires that before it hires any new employees who may have contact with residents, CYFD conducts criminal background record checks, consults any child abuse registry maintained by the Child Protective Services; and consistent with Federal, State, and local law, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. During the past 12 months all staff and contract persons who have been hired, who may have contact with residents, have had criminal background record checks. Exceeding standards, policy requires that ongoing background checks be conducted through CYFD's RAP Back program which notifies them of arrests and changes in criminal history record information in real time. The Agency policy states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. Unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work. Compliance with this standard was verified through a close reading of policy and other documentation provided, as well as a review of random personnel files pulled at the auditor's request, and through interviews with administrators.

### Standard 115.318 Upgrades to facilities and technologies

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

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ENRC has not acquired a new facility or made a substantial expansion or modification to existing facilities since August 20, 2012. The facility has, however, installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012. Documentation provided, as well as interviews with administrators, indicate PREA will be considered as updates occur in the future.

### Standard 115.321 Evidence protocol and forensic medical examinations

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

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CYFD completes administrative investigations only. New Mexico State Police does criminal investigations. There were no investigations or forensic interviews performed or indicated in past 12 months regarding ENRC. If and when a rape crisis center is not available to provide victim advocate services, the facility does not have qualified agency staff member to fulfill these duties, so other measures are taken to provide advocacy as soon as a community based advocate becomes available. The auditor verified that the Rape Crisis Center of Central New Mexico is available 24/7 365 days per year providing advocacy whenever it is needed. CYFD has MOU's with the Rape Crisis Center, and also with other organizations that provide similar services regionally. Alternatives to Violence (ATV) is the organization who provides care and advocacy for ENRC residents and they also have 24/7 services. However, if the alleged victim is transported to a hospital outside ATV catchment area, another organization (probably the Rape Crisis Center) would presumably provide immediate care and then ATV might provide follow-up as appropriate. In addition to providing information about rape crisis services CYFD has MOU's with, the agency provides a comprehensive list of such organizations throughout the state that would likely provide services regardless of not having an MOU. Captain Dina L. Romero of the New Mexico State Police Training Academy provided a letter explaining that all State Police Officers attend a 22 week academy in which they learn how to conduct criminal investigations. Academy classes include Sexual Assault Investigation, Crime Scene Processing/Evidence Preservation, Interview and Interrogation and Internal Affairs. Topics covered in these classes include legal issues, cultural competency, trauma and victim response, medical and mental health care issues of sexual assault victims, first responder responsibilities, evidence collection/processing and preservation, interviews with victims and suspects, ensuring proper documentation, working with the district attorney's and victim advocates, Miranda rights and application of Garrity rights. When conducting a sexual abuse investigation, the investigators follow a uniform evidence protocol that is developmentally appropriate for youth and based on the most recent edition of the DOJ's Office on Violence Against Women publication, A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents, or similarly comprehensive and authoritative protocols developed after 2011. Forensic examinations are offered without financial cost to the victim and are conducted by Sexual Assault Forensic Examiners (SAFEs) or (SANEs) at hospitals in Taos or Santa Fe. When SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations. The facility documents efforts to provide SANEs or SAFEs. These procedures are well stated in the agency Coordinated

Response plans and understood by the administrators and managers who will assure proper care is provided to alleged victims. The director of ATV also expresses confidence that the system is in place and will work for ENRC residents as well, if not better, than it works for victims from the community.

### **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.**

CYFD and ENRC ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. In the past 12 months no allegations of sexual abuse or sexual harassment were received regarding residents. The agency documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigation. Interviews of staff and residents indicated there have been no allegations, and that staff and residents believe allegations will be taken seriously.

### **Standard 115.331 Employee training**

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

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As verified by interviews with staff, CYFD trains all employees who may have contact with residents on the following required matters: zero-tolerance policy for sexual abuse and sexual harassment; how to fulfill responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; residents’ right to be free from sexual abuse and sexual harassment; the right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment; the dynamics of sexual abuse and sexual harassment in juvenile facilities; the common reactions of juvenile victims of sexual abuse and sexual harassment; how to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents; how to avoid inappropriate relationships with residents; how to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities, and including relevant laws regarding the applicable age of consent. Between trainings, the agency provides employees with annual refresher information about current policies regarding sexual abuse and sexual harassment. Verification was provided to the auditor showing that National Institute of Corrections training entitled “PREA: Your Role Responding to Sexual Abuse”, and other applicable PREA training, was completed by all staff. The other PREA training staff received includes PREA Compliant Searches, PREA Compliant Patrols and Inspections, PREA Compliant Grievance Procedure, PREA Compliant Client Privacy and Grooming, PREA Compliant Staffing Plans, PREA Compliant Grievance Procedure Additions for Juvenile Reintegration Center, PREA Emergency Grievances: JJS Substantial Threats, PREA Compliance – Employee Preparedness, PREA Compliance – Responding to Allegations, PREA Compliance – Client Education and Advocacy, Office of Inspector General Investigations in Juvenile Justice Services Facilities.

### Standard 115.332 Volunteer and contractor training

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

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Volunteers and contractors who will have contact with residents have been trained on their responsibilities under the agency policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. According to interviews and the Pre Audit Questionnaire, 4 volunteers are utilized at the time of the audit. The level and type of training provided to volunteers and contractors is based on the services they will provide and level of contact they will have with residents. All volunteers and contractors who will have contact with residents will have at least been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. The agency maintains documentation confirming that volunteers/contractors understand the training they have received and this documentation was provided for the audit team to review.

### 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)

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ENRC residents receive information at the time of intake about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. The facility provides resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills. The agency also ensures that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats. All residents admitted during the past 12 months have received this information in an age appropriate fashion, according to interviews and information provided. Many have received the information at previous placements as well. The agency maintains documentation of resident participation in PREA education sessions and this was provided to the auditor. The agency ensures that key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats, as verified in interviews of staff and residents, and observed by the audit team during the facility tour.

### Standard 115.334 Specialized training: Investigations

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

**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 does do its own administrative but not criminal investigations. The State Police is identified officially as the Criminal Investigators for CYFD, although, in some instances county or municipal law enforcement may be involved as appropriate. The State Police and CYFD has agreements and training to help facilitate cooperation and efficient working relationships across the state. If law enforcement declines to investigate an allegation, it gets investigated administratively. There is a Special Investigator under the Inspector General for CYFD who is assigned to cases of staff on client misconduct. Investigator Wendy Johnson was interviewed by phone and is very informed regarding PREA and in all investigative procedures and protocols she was questioned about. She trains all CYFD JJS staff regarding their responsibilities and may retrain them if questions arise regarding their understanding of their duties or regarding their performance. CYFD requires that investigators are trained in conducting sexual abuse investigations in confinement settings. Specialized training includes techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. Investigating agencies are required to maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations. Documentation was provided verifying that Investigator Wendy Johnson and Program Manager Frank Cortez completed NIC training: PREA: Investigating Sexual Abuse in a Confinement Setting.

**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.**

CYFD has written policies related to the training of medical and mental health practitioners who work regularly in its facilities. The training includes: How to detect and assess signs of sexual abuse and sexual harassment; How to preserve physical evidence of sexual abuse; How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and How and to whom to report allegations or suspicions of sexual abuse and sexual harassment. During interviews these staff, including the PREA Coordinator, demonstrated an understanding of their responsibilities. Counselor Victoria Goguen completed training entitled: PREA: Behavioral Health Care for Sexual Assault Victims in a Confinement Setting.

**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.**

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

### 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.**

ENRC uses information from the risk screening required by §115.341 to inform housing, bed, work, education, and program assignments. The facility prohibits placing lesbian, gay, bisexual, transgender, or intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status. The facility prohibits considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. The facility makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis. The facility uses all information obtained pursuant to § 115.341 and subsequently to make housing, bed, program, education, and work assignments for residents with the goal of keeping all residents safe and free from sexual abuse. Residents may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged. Placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident. A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration. Transgender and intersex residents shall be given the opportunity to shower separately from other residents. Interviews indicate there are no openly LGBTI residents at the facility. Also, there is always an administrator (someone who has access to all screening and assessment information) on call for after hours emergencies.

### Standard 115.351 Resident reporting

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

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

### **corrective actions taken by the facility.**

The agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. The facility provides at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the facility. There are no residents detained solely for civil immigration purposes at this time. The agency has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. Staff are required to document verbal reports "immediately". The facility does provide residents with access to tools to make written reports of sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. The agency has also established procedures for staff to privately report sexual abuse and sexual harassment of residents. Verification was provided that staff completed training on Resident Reporting. Posters state that anyone can report sexual abuse and provide the following options for reporting: notify any trusted staff, call the JJS Confidential Reporting Line: 1-855-563-5065, contact the JJS PREA Coordinator at [JJSPREA.Coordinator@state.nm.us](mailto:JJSPREA.Coordinator@state.nm.us), notify Medical or Behavioral Health (BH) Services, or write anonymous letter to PREA Reporting Office (POB 639; Las Cruces, NM 88004).

### **Standard 115.352 Exhaustion of administrative remedies**

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

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

The facility has an administrative procedure for dealing with resident grievances regarding sexual abuse. The facility policy allows a resident to submit a grievance regarding an allegation of sexual abuse at any time regardless of when the incident is alleged to have occurred. There is no time limit for a resident to submit a grievance regarding an allegation of sexual abuse, and the resident is not required to use an informal grievance process, or otherwise to attempt to resolve with staff, an alleged incident of sexual abuse. The facility's policy allows a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. The facility's procedure requires that a resident grievance alleging sexual abuse not be referred to the staff member who is the subject of the complaint. Exceeding standards, CYFD has policy that requires that all grievances be responded to within 5 days. Appeals are also responded to within 5 days. The facility policy permits third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and to file such requests on behalf of residents. Policy requires that if the resident declines to have third-party assistance in filing a grievance alleging sexual abuse, the agency documents the resident's decision to decline. Policy allows legal guardians of residents to file a grievance, including appeals, on behalf of such resident, regardless of whether the resident agrees to having the grievance filed on their behalf. Emergencies are dealt with immediately. Interviews conducted, and documentation received, indicate there have been no grievances alleging sexual abuse/harassment, or risk of abuse, that were filed in the past 12 months. The agency has a policy that limits its ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith.

### **Standard 115.353 Resident access to outside confidential support services**

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

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

The facility provides residents access to outside victim advocates for emotional support services related to sexual abuse and by providing, posting, and otherwise making accessible the mailing addresses and telephone numbers of local, State, or national victim advocacy or rape crisis organizations. Staff and administrators verify that the facility does inform residents, prior to giving them access to outside support services, the extent to which such communications will be monitored and of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant Federal, State, or local law. The facility provides residents with reasonable and confidential access to their attorneys or other legal representation, as well as reasonable access to parents or legal guardians. Interviews with staff and residents confirm a belief that outside support is available. Residents interviewed state they feel safe and are convinced they could report anything without retaliation, and could use outside services if needed, and that they can have private visits. This was echoed in interviews with the Director, PREA Managers, and specialized staff as well. Lee Phillips, Director of Alternatives to Violence (ATV), with which CYFD has a Memorandum of Understanding (MOU) had no reservations about the facility’s seriousness regarding informing residents of services available and following up accordingly. CYFD and ATV considers each agency to be true partners with clear roles in these efforts. The Training Acknowledgement signed by each resident spells out resident’s ability to access outside support services and legal representation.

#### **Standard 115.354 Third-party reporting**

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

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

The agency provides methods to receive third-party reports of resident sexual abuse or sexual harassment. Policy clearly states any staff member is required to take complaints and complaints can be anonymous. Anyone can call the reporting line. In addition, the facility distributes information on how to report resident sexual abuse or sexual harassment on behalf of residents by posting notices and posters in public areas. Also, the CYFD agency website explains ways to report, and provides methods to report.

#### **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.**

It is required that all staff report immediately and according to agency policy: any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred. Policy also requires the reporting of any retaliation against

residents or staff who reported such an incident, as well as any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The agency requires all staff to comply with any applicable mandatory child abuse reporting laws, as well as reports, as (and when) appropriate, to licensing agencies and Adult Protective Services. Apart from reporting to designated supervisors or officials and designated State or local service agencies, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. Medical and mental health practitioners are mandated reporters and are required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality. Upon receiving any allegation of sexual abuse, the facility promptly reports the allegation to the appropriate agency office and to the alleged victim's parents or legal guardians, unless the facility has official documentation showing the parents or legal guardians should not be notified. If the alleged victim is under the guardianship of the child welfare system, the report shall be made to the alleged victim's caseworker instead of the parents or legal guardians. If a juvenile court retains jurisdiction over the alleged victim, the facility head or designee shall also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation. Interviews with administrators, and a review of applicable policy, indicate compliance with this standard.

### Standard 115.362 Agency protection duties

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

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

When the agency or facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident. In the past 12 months, there have been no instances when the facility determined that a resident was subject to substantial risk of imminent sexual abuse. Verification of compliance with the standard was determined through interviews conducted and policies reviewed.

### Standard 115.363 Reporting to other confinement facilities

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

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

ENRC has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the Facility Director, as soon as possible (but no later than 72 hours), must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. Protective Services and law enforcement will also be contacted as appropriate. There has been one such report in the past 12 months and this protocol was followed faithfully. The agency is required to document that it has provided such notification within 72 hours of receiving the allegation. The agency/facility policy requires that allegations received from other facilities/agencies are investigated in accordance with the PREA standards. In the past 12 months, there have been no allegations of sexual abuse the facility received from other facilities.

### Standard 115.364 Staff first responder duties

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

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

The agency has a first responder policy for allegations of sexual abuse. The agency policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff or youth worker to respond to the report shall be required to separate the alleged victim and abuser and preserve and protect any crime scene until appropriate steps can be taken to collect any evidence. If the abuse occurred within a time period that still allows for the collection of physical evidence, the first responder requests that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. If the abuse occurred within a time period that still allows for the collection of physical evidence, the first responder should ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. Also, other notifications are made as in B115.361 above. All staff and administrators interviewed seem to know these first responder duties. In the past 12 months, there were no allegations, so first responder protocols were not utilized regarding any instance of sexual abuse.

### Standard 115.365 Coordinated response

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

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

The agency has developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership. This plan was provided to the auditor, and discussed during interviews with the Director, PREA Coordinator, PREA Compliance Manager, and others.

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

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

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

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

The agency, facility, or any other governmental entity responsible for collective bargaining on the agency's behalf has not entered into or renewed any collective bargaining agreement that restricts their ability to protect residents from abusers. Compliance with this standard was verified through a review of the union contract.

#### **Standard 115.367 Agency protection against retaliation**

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

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

The agency has a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff. The agency designates Eugene Brewster and Genoveno Carrillo with making sure retaliation is properly monitored for. The agency monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff. This includes status checks for residents. The agency monitors the conduct or treatment for at least 90 days and longer if needed and acts promptly to remedy any such retaliation. There have been no reports of retaliation in the past 12 months. ENRC's monitoring includes any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff.

#### **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.**

CYFD has a policy that residents who allege to have suffered sexual abuse may only be placed in isolation as a last resort. The facility policy requires that residents who are placed in isolation, because they allege to have suffered sexual abuse, have access to legally required educational programming, special education services, and daily large-muscle exercise. In the past 12 months no residents have been isolated or segregated for their protection according to interviews conducted and reports reviewed. Since ENRC does not have segregation, they would have to utilize room confinement protocols to provide this type of protection.

#### **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.**

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

#### **Standard 115.372 Evidentiary standard for administrative investigations**

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

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

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

#### **Standard 115.373 Reporting to residents**

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

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

CYFD has a policy requiring that any resident who makes an allegation that he or she suffered sexual abuse in the facility is notified as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation, and that the notification is documented. There have been no investigations regarding ENRC residents during the past 12 months, so the auditor did not have files to review to verify this practice, so compliance with this standard was verified through interviewing administrators and reviewing policy and forms that would be used. Following a resident's allegation that a staff member has committed sexual abuse against the resident, the facility subsequently informs the resident (unless the agency/facility has determined that the allegation is unfounded) whenever the staff member is no longer posted within the resident's unit; the staff member is no longer employed at the facility; the agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or the agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. Following a resident's allegation that he has been sexually abused by another resident, they will inform the alleged victim when they learn that the alleged abuser has been indicted on a charge related to sexual abuse within the facility or if they learn that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

### **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.**

Staff at ENRC are subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies, and this is made clear in the application and interview process, as well as new employee training. Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. No allegations have been made during the past 12 months, so the auditor had no instances of staff discipline to review. A review of applicable policy and interviews conducted indicate compliance with this standard.

### **Standard 115.377 Corrective action for contractors and volunteers**

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

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

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

sexual abuse or sexual harassment policies by a contractor or volunteer. Compliance with this standard was verified through a review of policy, other documentation, and interviews with administrators.

#### **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.**

Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding, or criminal finding, that the resident engaged in resident-on-resident sexual abuse. ENRC is not a secure facility and does not have the ability to place clients in segregation. If a client requires a higher level of security, law enforcement may be utilized and the client would have to go to another facility. The facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse and considers whether to require the offending resident to participate in such interventions as a condition of access to any rewards-based behavior management system or other behavior based incentives. Yet, access to general programming or education is not conditional on participation in such interventions. The agency disciplines residents for sexual contact with staff only upon finding that the staff member did not consent to such contact. The agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation. The agency prohibits all sexual activity between residents, but deems such activity to constitute sexual abuse only if it determines that the activity is coerced. Verification of compliance with this standard was based on a review of policy and interviews conducted. Since there have been no allegations of sexual abuse or harassment during the past 12 months, the auditor had no disciplinary sanctions to review.

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

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

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

All residents at this facility who have disclosed any prior sexual victimization during a screening pursuant to §115.341 are offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. Since February 2016, three residents disclosed prior victimization during screening and were appropriately offered a follow up meeting with a mental health practitioner. Medical and mental health staff maintain secondary materials documenting compliance with the above required services. All residents who have previously perpetrated sexual abuse, as indicated during the screening pursuant to § 115.341, are offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening. Mental health staff maintain secondary materials documenting compliance with the above required services. The information shared with other staff is strictly limited to informing security and management decisions, including treatment plans, housing, bed, work, education, and program assignments, or as otherwise required by federal, state, or local law.

#### **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.**

According to agency policy and interviews conducted, resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, which will probably be in Taos. The residents answered questions in such a way to show they believe they will be cared for should something happen to them. Also, facility policies spell this out. In addition, the auditor spoke with the director of Alternatives to Violence, Lee Phillips, who verified they have the staff and resources to assist at the Taos hospital. The nature and scope of such services are to be determined by medical and mental health practitioners according to their professional judgment. Medical and mental health staff document the timeliness of emergency medical treatment and crisis intervention services provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning sexually transmitted infection prophylaxis. Resident victims of sexual abuse while incarcerated are offered timely information about and timely access to sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Treatment services will be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with the investigation. Since all the residents at the facility are male, parts of this standard relating to female residents do not apply.

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

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

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

The facility offers medical and mental health evaluation on all residents, but these services may not be offered onsite. They may be provided at other CYFD facilities or in the community. This includes medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility, as required by this PREA standard. Resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate. Treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such history. However, interviews indicate these residents may ultimately have to be housed at other facilities. The evaluation and treatment of such victims includes, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. The facility provides such victims with medical and mental health services consistent with the community level of care. All residents at ENRC are male so parts of this standard relating to female residents do not apply. Compliance with this standard was verified through interviews and policy review. Policy 5.24 B Section 8.7 states, “If continued BH treatment is required for the client victim, BH clinicians will ensure that the client is cared for in-facility and/or transported to an external facility, as appropriate.”

**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.**

According to policy, ENRC conducts a sexual abuse incident review at the conclusion of every sexual abuse criminal or administrative investigation, unless the allegation has been determined to be unfounded. In the past 12 months, there have been no criminal and/or administrative investigations of alleged sexual abuse completed at the facility, so no incident reviews were required. The Program Manager and PREA Coordinator verify that in the event of an investigation, the facility will conduct a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation. The sexual abuse incident review team will include upper-level management officials and allow for input from line supervisors, investigators, and medical or mental health practitioners. The review team considers whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; considers whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or, gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; examines the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; assesses the adequacy of staffing levels in that area during different shifts; assesses whether monitoring technology should be deployed or augmented to supplement supervision by staff; and prepares a report of its findings, including but not necessarily limited to determinations made pursuant to this section, and any recommendations for improvement, and submits such report to the facility head and PREA compliance manager. CYFD Director of JJS Tamera Marcantel, as well as ENRC Program Manager Frank Cortez, assured the auditor that these processes are taken very seriously by the agency and the facility will certainly implement the recommendations for improvement or document its reasons for not doing so.

**Standard 115.387 Data collection**

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

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

CYFD JJS PREA Coordinator Eugene Brewster, JJS Performance/Policy Bureau Chief Greg Nelson, ENRC Superintendent Frank Cortez, and ENRC PREA Compliance Manager Genoveno Carrillo verify that ENRC collects accurate, uniform data for every allegation of sexual abuse using a standardized instrument and set of definitions and provides this to CYFD for annual reporting. The facility maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

**Standard 115.388 Data review for corrective action**

- 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.**

Data collected and aggregated pursuant to §115.387 is reviewed in order to improve the effectiveness of sexual abuse prevention, detection, and response by identifying problem areas; taking corrective actions; and preparing an annual report. The annual report includes a comparison of the current year's data and corrective actions with those from prior years and provides an assessment of the agency's progress at each facility as well as the agency as a whole. The agency makes its annual report readily available to the public. The annual reports are approved by the agency head after redactions are made which are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility. The auditor reviewed the CYFD Annual Report available at <https://cyfd.org/facilities/prison-rape-elimination-act-prea>.

### **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.**

CYFD ensures that incident-based and aggregate data are securely retained and requires that aggregated sexual abuse data is made available to the public annually after identifiers have been removed. The agency maintains this data for at least 10 years. Information for the previous year was reviewed by the audit team.

### **AUDITOR CERTIFICATION**

I certify that:

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

D. Will Weir

08-09-2017

Auditor Signature

Date