Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Report 07-30-2020

Auditor Information

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Company Name: PREA America, LLC	
Mailing Address: P. O. Box 1473	**City, State, Zip:** Raton, NM 87740
Telephone: 405-945-1951	**Date of Facility Visit:** March 5 & 6, 2020

Agency Information

Name of Agency Juvenile Justice Services (JJS)	**Governing Authority or Parent Agency** *(If Applicable)* New Mexico Children, Youth, & Families Department (CYFD)
Physical Address: 1120 Paseo De Peralta	**City, State, Zip:** Santa Fe, NM 87501
Mailing Address: P.O. Drawer 5160	**City, State, Zip:** Santa Fe, NM 87501

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

Agency Website with PREA Information: https://cyfd.org/facilities/prison-rape-elimination-act-prea

Agency Chief Executive Officer

Name: Nick Costales, Deputy Director of Field Services; and Tamera Marcantel, Deputy Director of Facilities [New Mexico Children, Youth, & Families Department; Juvenile Justice Services]

Email: nick.costales@state.nm.us and Tamera.Marcantel@state.nm.us	**Telephone:** 505-288-1659 and 505-216-8593

Agency-Wide PREA Coordinator

Name: Eugene Brewster

Email: Eugene.Brewster@state.nm.us	**Telephone:** 505-252-8020

PREA Coordinator Reports to:	Number of Compliance Managers who report to the PREA Coordinator:
Greg Nelson, Bureau Chief; Performance/Policy Bureau CYFD JJS	6

Facility Information

Name of Facility: Albuquerque Girls Reintegration Center (AGRC)			
Physical Address: 3409 Pan American Freeway, NE		**City, State, Zip:** Albuquerque, NM 87107	
Mailing Address (if different from above): Click or tap here to enter text.		**City, State, Zip:** Click or tap here to enter text.	
The Facility Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☒ State	☐ Federal

Facility Website with PREA Information: https://cyfd.org/facilities/prison-rape-elimination-act-prea

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

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

☐ ACA

☐ NCCHC

☐ CALEA

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

☒ N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:
PREA Compliance Assessment on November 30, 2019

Facility Administrator/Superintendent/Director

Name: Tina Garcia	
Email: TinaM.Garcia@stae.nm.us	**Telephone:** 505-841-4816

Facility PREA Compliance Manager

Name: Leonard Sisneros	
Email: Leonard.Sisneros@state.nm.us	**Telephone:** 505-218-1371

Facility Health Service Administrator ☒ N/A	
Name: Click or tap here to enter text.	
Email: Click or tap here to enter text.	**Telephone:** Click or tap here to enter text.

Facility Characteristics	
Designated Facility Capacity:	12
Current Population of Facility:	2
Average daily population for the past 12 months:	4
Has the facility been over capacity at any point in the past 12 months?	☐ Yes ☒ No
Which population(s) does the facility hold?	☒ Females ☐ Males ☐ Both Females and Males
Age range of population:	16-21
Average length of stay or time under supervision	3 months
Facility security levels/resident custody levels	Low

Number of residents admitted to facility during the past 12 months	14
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:	14
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *10 days or more:*	14
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	☐ Yes ☒ No
Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	☐ Federal Bureau of Prisons ☐ U.S. Marshals Service ☐ U.S. Immigration and Customs Enforcement ☐ Bureau of Indian Affairs ☐ U.S. Military branch ☐ State or Territorial correctional agency ☐ County correctional or detention agency ☐ Judicial district correctional or detention facility ☐ City or municipal correctional or detention facility (e.g. police lockup or city jail) ☐ Private corrections or detention provider

	☒ Other - please name or describe: CYFD Protective Services ☐ N/A
Number of staff currently employed by the facility who may have contact with residents:	16
Number of staff hired by the facility during the past 12 months who may have contact with residents:	7
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	0
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0
Number of volunteers who have contact with residents, currently authorized to enter the facility:	20
Physical Plant	
Number of buildings: **Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.**	1
Number of resident housing units: **Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.**	1
Number of single resident cells, rooms, or other enclosures:	0
Number of multiple occupancy cells, rooms, or other enclosures:	4 rooms, with 3 beds each
Number of open bay/dorm housing units:	0

Number of segregation or isolation cells or rooms (for example, administrative, disciplinary, protective custody, etc.):	0
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	☐ Yes ☒ No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	☐ Yes ☒ No

Medical and Mental Health Services and Forensic Medical Exams

Are medical services provided on-site?	☐ Yes ☒ No
Are mental health services provided on-site?	☒ Yes ☐ No
Where are sexual assault forensic medical exams provided? Select all that apply.	☐ On-site ☐ Local hospital/clinic ☐ Rape Crisis Center ☒ Other (please name or describe): Albuquerque SANE Collaborative

Investigations

Criminal Investigations

Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:	0
When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.	☐ Facility investigators ☐ Agency investigators ☒ An external investigative entity
Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)	☐ Local police department ☐ Local sheriff's department ☒ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: Click or tap here to enter text.) ☐ N/A

Administrative Investigations

Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	2
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply	☒ Facility investigators ☒ Agency investigators ☐ An external investigative entity

Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	☐ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: Click or tap here to enter text.) ☒ N/A

Audit Findings

Audit Narrative

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

Communication with the PREA Coordinator specific to the PREA audit of AGRC, to discuss the audit process, audit preparation, the Pre-Audit Questionnaire (PAQ), and supporting documents and elements of the On-Site Visit, started in January 2020. The PREA America Audit Team consisted of Project Manager Tom Kovach and DOJ Certified PREA Auditor Will Weir. The Audit Notice Posting was sent, with instructions to print on colored paper and about proper distribution of the posting. An alternative-language posting was also made available. Proof of posting was verified by emailed photos of the various locations in the facility where the posting was placed. The date of the email was used to verify the that the posts were in place the required minimum of six weeks prior to the On-Site Audit, along with observations of the posting during the physical plant tour. Postings were up by January 24, 2020.

During the Pre-Audit Phase, an extensive desk audit of the facility/agency was conducted, including of its PAQ, policies, and procedures, as well as of supporting documentation. Several emails were exchanged, to clarify issues and to ask for specific documentation for proof of practice. This phase of the audit was used to collaborate with the facility staff on questions and concerns regarding documenting compliance. The communication with the facility staff was used not only to understand the policies and procedures unique to the facility, but also to understand how PREA was put into practice. Internet research was done on the facility.

All documents received were reviewed, including logs, training files, and curricula. To verify compliance with regulations regarding background checks, 5-year rechecks, and child abuse registries, such files were reviewed of randomly selected staff. Files of each resident were reviewed to verify PREA education and PREA Screenings. Phone calls were made to listed advocates, to verify the advocacy required by the Standards.

The On-Site Audit started with a briefing, which included confirmation of current population, review of agenda and logistics, discussion of mandatory reporting, and clarifying the need to allow any staff or

resident who requests an interview to get one. The Audit Team checked to see if there were questions or concerns. The On-Site Audit started on the afternoon of March 5th in order to ensure that everyone could be interviewed. The facility had 2 residents. The Program Manager, the Compliance Manager, the PREA Coordinator, and the Bureau Chief were all at the Entrance Briefing. The Exit Briefing, conducted on the afternoon of March 6th, included these same people, with the addition of the agency's PREA Management Analyst and the agency's Deputy Director of Facilities.

The Site Review included obtaining and studying the facility diagram of the physical plant. The supervision and movement of staff and residents were observed, along with casual conversation to ascertain whether observations made were of "normal" supervision and movement. Random checks were made to assure that doors intended to be secured were locked. Random checks of PREA Hotline phones for functionality were made. All housing units and bathroom facilities were inspected for compliance for cross-gender supervision. All areas of the physical plants were observed, with attention to those areas which statistically are high-risk for sexual abuse. PREA Postings in the Visitation area, including third-party reporting postings, were checked. Confirmation of the availability to staff of First Responder Duties was also a part of the tour. Blind spots were identified, and procedures for checking them were verified.

Both residents and all available staff were interviewed. Interviews of staff included gender, shift, and post diversity. Interviews were in a conversational manner, to gain the confidence of those interviewed and to put them at ease, so the Audit Team could better understand their comprehension of PREA and of its practice in the facility.

Interviews were conducted with staff in the following positions: Agency Head Designee, Agency PREA Coordinator, Superintendent, Agency Human Resources, Agency Contract Monitor, Local Investigator, PREA Compliance Manager, Program Manager, mental health staff, SANE Nurse, staff who perform Screening and Intake, staff who monitor for Retaliation, Incident Review Team, and staff who would monitor youth if they were placed in room confinement. An additional 6 staff were interviewed, representing various stations, housing units, shifts, and genders. A total of 10 unique Specialized Staff interviews were conducted, including those conducted by telephone prior to the On-Site Audit. 6 "random staff" were interviewed. This is a very small facility with a very small population of residents; so, despite coming over two days, only 6 staff could be interviewed beyond those who perform specialized functions.

The Exit Briefing addressed all aspects of the Audit to date. No determination of compliance was given. The recap of the aggregated information obtained and observed was summarized. By request of the facility staff, to assist in furthering the efforts of the facility to prevent and detect sexual abuse and harassment, this summary included a SWOT briefing: a review of Strengths, Weaknesses, Opportunities, and Threats.

Interviews and policy reviews indicated that the facility has started accepting residents that are not under the jurisdiction of the juvenile justice system without consultation with the PREA Coordinator and without making changes in policies and procedures that would accommodate this change while maintaining compliance with the PREA Standards. These concerns were brought up during the Exit Briefing and administrators agreed to work toward compliance. However, during the 30 days after the On-Site Audit the nation experienced the Covid-19 Pandemic and progress was delayed. The issuance of the Interim Report triggered a Corrective Action Period (CAP) not to exceed 180 days. During this time the Auditor and the agency jointly developed a Corrective Action Plan (also called a CAP) to bring the agency into full compliance. This plan was followed, bringing the agency and facility into

compliance. See details at the end of the section labeled, “Summary of Audit Findings” and in the narratives related to each of the applicable Standards.

Facility Characteristics

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

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. It is noteworthy that the first word in the name of this model, “*Cambiar*,” is Spanish for “To change”. JJS continues to hold young people accountable, while providing for their rehabilitation and preparing them for healthy adulthood. JJS protects them from harm, while continuing to provide for public safety. According to agency sources, major initiatives include:
Developing smaller, secure regional facilities across the state.
Creating smaller, safer, more nurturing living units/groups (therapeutic communities).
Implementing youth-centered unit management and milieu therapy.
Developing individualized service plans (ISPs), addressing carefully assessed needs, strengths, and risks.
Having staff, at each facility, who are Youth Care Specialists, who have received training that provides them with security and therapeutic skill sets.
Providing rich programming for residents, including education, vocational preparation, behavioral health, medical services, and other services.

The CYFD Juvenile Reintegration Centers (JRCs) provide a safe environment in a group home setting for clients on Supervised Release and Probation. The JRCs collaborate with CYFD and community team members to provide clients with programming and services. JRCs assist clients in developing individualized plans to focus on their specific needs and goals to promote healthy life choices. Programming to develop and support life skills may include: Daily Living (sobriety and relapse prevention planning); Self-Care (personal hygiene and coping mechanisms); Housing; Money Management, and Transportation (independent living); Education; Employment and Job Readiness; Relationships and Communication (healthy relationships, boundaries, conflict resolution, parenting); Community Engagement; Career and Education Planning; and Future Planning.

This reintegration center is a single building overlooking the Juvenile Justice Complex of Facilities nearby. The outside area is fenced in and has two locked storage buildings. Some visitation takes place here when the weather permits. The building is bifurcated into the living area with day room, staff desk, exercise room, laundry, library; and a kitchen and dining area. Food storage and the food manager’s office are located near the kitchen. There are two bathrooms and four rooms (two on either side of the hall) with three beds. The front has a reception area, in which the door is monitored to allow people in. There are also offices for the Program Manager, the Social Worker, the Counselor’s, and JCPS; a Conference Room; and storage. There are no cameras; however, there are plans to install them. Transportation to school and to other functions is provided.

Summary of Audit Findings

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

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

Standards Exceeded

Number of Standards Exceeded: 0
List of Standards Exceeded:

Standards Met

Number of Standards Met: 40 on Interim Report; 43 on the Final Report

Standards Not Met

Number of Standards Not Met: 3 on Interim Report; 0 on Final Report
List of Standards Not Met:

Standard 115.311 (Zero tolerance of sexual abuse and sexual harassment; PREA coordinator): Some interviews with agency administrators, as well as with facility administrators, indicated that, during the year prior to the On Site Audit, the facility was required, by the Governor's Cabinet Secretary, without adequate consideration of protocols for sexual safety, and without consultation with the PREA Coordinator, to start accepting some residents who are not in the custody of JJS. In other words, some residents are admitted to the facility who have a history of being abused and/or neglected and have cases with Child Protective Services (CPS) rather than cases charging the youth with law violations. In the past, AGRC was for youth with cases that mandated that their criminal behavior be addressed. Policies developed for "delinquent" youth may not be applicable to other youth. Due to the layout of the building, all residents house and program together, causing some concerns at the time of the On Site Audit and Interim Report, regarding sexual safety and whether the agency has adequate leverage to protect residents and/or to impose consequences in the event abuse occurs. Additionally, if the agency does have the leverage needed, staff had questions regarding what this leverage is and what policies to consult.

Corrective Action: During the CAP, the agency and facility was able to come into compliance implementing the following changes and updates. The CYFD JJS Performance & Policy Bureau Chief had a telephonic meeting with JJS Field Deputy Director regarding the inclusion of the PREA Coordinator in any future plans that may have an effect on PREA compliance. They specifically discussed PREA Standards 115.311(b) and 115.318(a). Documentation was provided to the auditor verifying this discussion and recording in writing that the Deputy Director understands the provisions in question and pledges to "require that the PREA Coordinator be included in any facility planning whether to program, or physical plant or in any manner that may otherwise have the potential to affect the agency's ability to prevent, detect and respond to sexual abuse or harassment." After this training was completed the auditor interviewed the PREA Coordinator who was able to verify with examples that this change has been implemented. Examples included planning for the youth at AGRC, as well as agencywide, to deal with the Covid-19 Pandemic. Some youth have had to be housed in locations different from their assigned placement due to the agency's need to prevent spread and prepare for where to house youth in the event a youth tests positive for the virus. The PC verifies that he is being

consulted and sexual safety is being considered in all ways, relevant to this Standard known to him. He has the time, actionable information, and authority, to effectively coordinate PREA in the agency. Also, since PREA Compliance Managers are fulfilling their duties in addition to the duties enumerated in their job descriptions, documentation of their assignments as PCMs was updated to assure that all PCM's in the agency also have the time, authority and accountable to perform their PREA related duties.

The second Standard related to this issue is Standard 115.318 (Upgrades to facilities and technologies): The facility licensure has been modified so that they can start providing care for youth alleged to be Deprived (abused and/or neglected), in addition to those youth placed in CYFD JJS custody due to adjudicated Delinquent acts. Some interviews indicated that the agency did not consider the effect of the modification upon the agency's ability to protect residents from sexual abuse. Therefore, the Interim Report indicated that the agency had not clearly shown compliance with this Standard.

Corrective Action: Some of the issues addressed during the CAP were addressed together, so some narratives in this report repeat information that applies in multiple sections. The CYFD JJS Performance & Policy Bureau Chief had a telephonic meeting with JJS Field Deputy Director regarding the inclusion of the PREA Coordinator in any future plans that may have an effect on PREA compliance. They specifically discussed PREA Standards 115.311(b) and 115.318(a). Documentation was provided to the auditor verifying this discussion and recording in writing that the Deputy Director understands the provisions in question and pledges to "require that the PREA Coordinator be included in any facility planning whether to program, or physical plant or in any manner that may otherwise have the potential to affect the agency's ability to prevent, detect and respond to sexual abuse or harassment." After this training was completed the auditor interviewed the PREA Coordinator who was able to verify with examples that this change has been implemented. Examples included planning for the youth at AGRC, as well as agencywide, to deal with the Covid-19 Pandemic.

The final Standard related to this issue is Standard 115.378 (Interventions and disciplinary sanctions for residents): The recent addition of residents to the facility who are not under the authority of the juvenile justice system adds complexity to the ability to comply with 115.378 (b). According to interviews during the audit, youth under court order to comply with JJS may get different consequences for committing sexual abuse than youth in the program through no fault of their own. The agency simply does not have the same leverage or control over youth the courts consider to be deprived as it does over youth the courts consider to be delinquent. The Standard requires that disciplinary sanctions be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories. Staff expressed confusion regarding what leverage they have with youth not in JJS custody, and indicated a need for guidance and policy regarding how to comply with this Standard in the imposing of sanctions in the event a JJS youth and a CPS youth were involved in sexual abuse or sexual harassment. Policy appeared to address this process for JJS youth, but not for CPS youth, in the absence of criminal proceedings

Corrective Action: During the CAP, procedures were developed to address Standard 115.378 (Interventions and disciplinary sanctions for residents) so that all provisions of the Standard can be followed in the event of incidents of sexual abuse or sexual harassment by any residents at AGRC. The Deputy Director of Facilities and the Deputy Director of Field Services issued a Directive (20-004) clarifying that all youth placed in JJS facilities will be subject to the same protections and administrative expectations. It states, "For the purposes of PREA, all individuals (identified in JJS policy and procedure as clients) housed at JJS facilities/centers are afforded the protections of PREA and subject to its administrative expectations regardless of their CYFD-custody status." The Directive is being

posted on the agency website with other policies and has been added to distribution and training lists. Due to precautions related to the COVID-19 Pandemic, the facility is not currently housing clients, therefore additional proof of implementation of the new directives is not required at this time.

PREVENTION PLANNING

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

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

115.311 (a)

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

115.311 (b)

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

115.311 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's

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

The Albuquerque Girls Rehabilitation Center (AGRC) 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, the ambience is one of commitment to the zero-tolerance policy and to the safety of the residents. The agency employs and designates an upper-level, agency-wide PREA Coordinator, who should have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA Standards in the facility. The facility PREA Compliance Manager is one of several Compliance Managers who report to the PREA Coordinator. The Agency-Wide PREA Coordinator reports to the Bureau Chief of Performance and Policy. Some interviews with agency administrators, as well as with facility administrators, indicated that, during the past year, the facility was required, by the Governor's Cabinet Secretary, without adequate consideration of protocols for sexual safety, and without consultation with the PREA Coordinator, to start accepting some residents who are not in the custody of JJS. Some residents are now admitted to the facility who have a history of being abused and/or neglected and have cases with Child Protective Services (CPS) rather than cases with dispositions mandating them to be in the custody of JJS.

Corrective Action: During the CAP, the agency and facility was able to come into compliance implementing the following changes and updates. The CYFD JJS Performance & Policy Bureau Chief had a telephonic meeting with JJS Field Deputy Director regarding the inclusion of the PREA Coordinator in any future plans that may have an effect on PREA compliance. They specifically discussed PREA Standards 115.311(b) and 115.318(a). Documentation was provided to the auditor verifying this discussion and recording in writing that the Deputy Director understands the provisions in question and pledges to "require that the PREA Coordinator be included in any facility planning whether to program, or physical plant or in any manner that may otherwise have the potential to affect the agency's ability to prevent, detect and respond to sexual abuse or harassment." After this training was completed the auditor interviewed the PREA Coordinator who was able to verify with examples that this change has been implemented. Examples included planning for the youth at AGRC, as well as agencywide, to deal with the Covid-19 Pandemic. Some youth have had to be housed in locations different from their assigned placement due to the agency's need to prevent spread and prepare for where to house youth in the event a youth tests positive for the virus. The PC verifies that he is being consulted and sexual safety is being considered in all ways, relevant to this Standard known to him. He has the time, actionable information, and authority, to effectively coordinate PREA in the agency. Also, since PREA Compliance Managers are fulfilling their duties in addition to the duties enumerated in their job descriptions, documentation of their assignments as PCMs was updated to assure that all PCM's in the agency also have the time, authority and accountable to perform their PREA related duties.

Analysis: Considered for compliance with this Standard are interviews with agency administrators, facility administrators, and the documentation (described above) provided during the CAP. Also

reviewed were agency policy mandating zero tolerance (Policy 5.24 A-C); and agency and facility organizational charts.

Finding: AGRC is in full compliance with this Standard.

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

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

115.312 (a)

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

115.312 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency reports having one contract for the confinement of its residents. This contract is with San Juan County Juvenile Services. JJS complies with this PREA Standard by requiring that facility to be compliant, and by monitoring that compliance. The Navajo Nation includes part of San Juan County, New Mexico. Both the Nation and the County have been severely affected by the COVID-19 Pandemic. The deadlines for the full in-person contract monitoring, as well as the requirement for the San Juan

County Juvenile Detention Center PREA Audit will be extended so that the work can be completed safely.

However, one problem was addressed during this audit. The CYFD contract for confinement of residents in San Juan County was renewed not with the PREA specific wording included in the previous contract, but with language that inadvertently left out explicit mention of PREA requirements. The new contract requires adherence with all federal guidelines, and requires monitoring, but does not specifically mention PREA. Although this item was not listed in the Interim Report, during the CAP, CYFD and the San Juan County Juvenile Detention Center came to an agreement to add the previous language back into the contract.

Analysis: Evidence used to determine compliance with this Standard includes: Interview with the Contract Administrator; Contract with San Juan County Juvenile Services; and documentation of contract monitoring from 2019. Contract monitoring is due to be conducted again, but it is delayed as a precaution required due to the Covid-19 pandemic.

Standard 115.313: Supervision and monitoring

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

115.313 (a)

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

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

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

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

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

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

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

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

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

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

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

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

115.313 (b)

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

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

115.313 (c)

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

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

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

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

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

115.313 (d)

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section? ☒ Yes ☐ No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns? ☒ Yes ☐ No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan? ☒ Yes ☐ No

115.313 (e)

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities) ☐ Yes ☐ No ☒ NA
- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) ☐ Yes ☐ No ☒ NA
- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

AGRC develops, documents, and makes its best efforts to comply with a staffing plan that provides for adequate levels of staffing, to protect residents against abuse. In calculating adequate staffing levels, AGRC 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 4. 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, in order to ensure compliance with the staffing plan. Staffing plans, policies, and reviews were provided to the Audit Team for review.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with Superintendent, PREA Coordinator, and all available staff; Documentation of staffing plan development process; Staffing plan; Documentation of Annual Reviews; staff and resident rosters; schedules; and policies.

Finding: AGRC is fully compliant with this Standard.

Standard 115.315: Limits to cross-gender viewing and searches

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

115.315 (a)

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

115.315 (b)

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

115.315 (c)

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

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

115.315 (d)

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

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

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

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

115.315 (e)

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

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

115.315 (f)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

No cross-gender searches of any kind are permitted by the Children, Youth, & Families Department (CYFD), absent exigent circumstances, which have to be documented. The facility does not conduct any kind of cross-gender searches of residents, except in fully documented, justified, exigent circumstances, or when performed by medical practitioners. According to interviews and documentation provided, no cross-gender searches have been conducted in the past year. Residents are able to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. 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 in how to engage 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.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with staff and residents; Policies and procedures (Directive 16-001, 004); Training curricula regarding searches, including cross-gender pat-down searches and searches of transgender and intersex residents; and Staff training logs.

Findings: AGRC is fully compliant with this Standard.

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

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

115.316 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) ☒ Yes ☐ No

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

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

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

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

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

115.316 (b)

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

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

115.316 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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 ß 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. Given the small size of the facility, and the notably small size of the present and average actual population of the facility, it will frequently be the case that the facility does not house any clients who are disabled or who are limited in English proficiency. However, agency employees assert that, in the event that they do have residents with a disability, and/or with limited English proficiency, they would make the appropriate accommodations to assist them in understanding PREA. JJS provides a list of interpreter services with instructions and protocols for utilizing the services, including for emergencies. Also provided are the policies that CYFD JJS applying applies to all facilities, regarding for providing close supervision, when needed by residents

with developmental disabilities and serious mental health needs. These policies address the 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.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with administrators, residents, and all available staff; policies (Policy 5:24 B -4, P.4.13 -14.); Contracts with interpreters; written materials used for effective communication about PREA with residents with disabilities, limited reading skills, or limited English proficiency; Client and Family Handbook; Voiance Language Services information; and documentation of staff training on PREA-compliant practices for residents with disabilities.

Finding: AGRC is fully compliant with this Standard.

Standard 115.317: Hiring and promotion decisions

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

115.317 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

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

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

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

115.317 (b)

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

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

115.317 (c)

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

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

- Before hiring new employees who may have contact with residents, does the agency, consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? ☒ Yes ☐ No

115.317 (d)

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

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

115.317 (e)

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

115.317 (f)

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

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

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

115.317 (g)

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

115.317 (h)

- Does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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 contracted personnel who have been hired, who may have contact with residents, have had criminal background record checks. 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. 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.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with Human Resources staff; Policies on promotion and hiring of employees and contractors, including policies governing criminal background checks and checks of child abuse registries, of current employees who may have contact with residents (5.24 A -4.1-4.8 and 4.2); Files of persons hired or promoted in the last 12 months, to determine whether proper criminal record background checks and checks of child abuse registries have been conducted, and whether questions regarding past conduct were asked and answered; Files of personnel hired in the past 12 months, to determine that the agency has completed checks consistent with 115.317(c); and documentation of background records checks, and checks of child abuse registries, of current employees at five-year intervals, when applicable.

Finding: AGRC is fully compliant with this Standard.

Standard 115.318: Upgrades to facilities and technologies

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

115.318 (a)

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

115.318 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

There have been no significant modifications of physical structures, but the facility licensure has been modified so that they can start providing care for youth alleged to be Deprived (abused and/or neglected), in addition to youth placed in CYFD JJS custody due to adjudicated Delinquent acts.

Corrective Action: During the CAP, the agency and facility was able to come into compliance implementing the following changes and updates. The CYFD JJS Performance & Policy Bureau Chief had a telephonic meeting with JJS Field Deputy Director regarding the inclusion of the PREA Coordinator in any future plans that may have an effect on PREA compliance. They specifically discussed PREA Standards 115.311(b) and 115.318(a). Documentation was provided to the auditor verifying this discussion and recording in writing that the Deputy Director understands the provisions in question and pledges to "require that the PREA Coordinator be included in any facility planning whether to program, or physical plant or in any manner that may otherwise have the potential to affect the agency's ability to prevent, detect and respond to sexual abuse or harassment." After this training was completed the auditor interviewed the PREA Coordinator who was able to verify with examples that this change has been implemented. Examples included planning for the youth at AGRC, as well as agencywide, to deal with the Covid-19 Pandemic. Some youth have had to be housed in locations different from their assigned placement due to the agency's need to prevent spread and prepare for where to house youth in the event a youth tests positive for the virus. The PC verifies that he is being consulted and sexual safety is being considered in all ways, relevant to this Standard known to him. He has the time, actionable information, and authority, to effectively coordinate PREA in the agency. Also, since PREA Compliance Managers are fulfilling their duties in addition to the duties enumerated in their job descriptions, documentation of their assignments as PCMs was updated to assure that all PCM's in the agency also have the time, authority and accountable to perform their PREA related duties.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with agency and facility administrators; program descriptions and related laws and policies; and the Site Review. Some interviews indicate that the agency did not consider the effect of the modification upon the agency's ability to protect residents from sexual abuse.

Findings: AGRC is fully compliant with this Standard.

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

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

115.321 (a)

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

115.321 (b)

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

- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (c)

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

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

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

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

115.321 (d)

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

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

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

115.321 (e)

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

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

115.321 (f)

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

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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 AGRC. If and when a rape crisis center is not available to provide victim advocate services, the facility does not have a 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 Audit Team verified that the Rape Crisis Center of Central New Mexico is available 24-7, 365 days a year, providing advocacy whenever it is needed. CYFD has MOU's with the Rape Crisis Center, as well as with other organizations that provide similar services regionally. Safehouse is the organization which provides care and advocacy for AGRC residents. If the alleged victim is transported to a hospital outside Safehouse's catchment area, another organization (probably the Rape Crisis Center) would presumably provide immediate care; and then, Safehouse might provide follow-up as appropriate. In addition to providing information about rape crisis services with whom CYFD has MOU's, the agency provides a comprehensive list of such organizations throughout the state, any of which would likely provide services regardless of not having an MOU. All State Police Officers attend a multiple-month 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 to it; 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 Attorneys 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 which is 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 Sexual Assault Nurse Examiners (SANEs) at nearby hospitals. When SAFEs or SANEs are not available, a qualified medical practitioner performs forensic medical examinations. AGRC documents efforts to provide SAFEs and SANEs. These procedures are well-stated in JJS's Coordinated Response plans, and they are understood by the administrators and managers, who will assure proper care is provided to alleged victims.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with randomly selected staff and with SANE Nurse. Uniform evidence protocol, governing how to obtain usable physical evidence in allegations of sexual abuse. Documentation of efforts to provide SAFEs or SANEs. Documentation that forensic medical exams are offered for free. Documentation of agreements with rape crisis centers for services. Policy 5.24 b-9, State Policy Evidence Protocol.

Findings: AGRC is fully compliant with this Standard.

Standard 115.322: Policies to ensure referrals of allegations for investigations

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

115.322 (a)

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

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

115.322 (b)

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

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

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

115.322 (c)

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

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

CYFD and AGRC ensure 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. JJS documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigation. Interviews of staff and residents indicated that there have been no allegations, and that staff believe allegations will be taken seriously.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with Agency Head and Investigative staff; policies and procedures governing investigations of allegations of sexual abuse and sexual harassment (Policy 5.24 C -Sections 4.2,10.0); and data collection for the past several years.

Finding: AGRC is fully compliant with this Standard.

TRAINING AND EDUCATION

Standard 115.331: Employee training

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

115.331 (a)

- Does the agency train all employees who may have contact with residents on its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on the right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on the dynamics of sexual abuse and sexual harassment in juvenile facilities? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on the common reactions of juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to avoid inappropriate relationships with residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on relevant laws regarding the applicable age of consent? ☒ Yes ☐ No

115.331 (b)

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

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

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

115.331 (c)

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

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

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

115.331 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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; 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, 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 Audit Team, showing that the National Institute of Corrections training, entitled "PREA: Your Role Responding to Sexual Abuse", and other applicable PREA trainings, were 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; and Office of Inspector General Investigations in Juvenile Justice Facilities.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with randomly selected staff; training policy and procedures (Policy 5.24A-Section 5); staff training curricula; and samples of records documenting staff training regarding compliance with this Standard.

Finding: AGRC is fully compliant with this Standard.

Standard 115.332: Volunteer and contractor training

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

115.332 (a)

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

115.332 (b)

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

115.332 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The level and type of training provided to volunteers, and to any potential future contractors, is based on the services they will provide, and on the 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.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with staff who would facilitate and supervise contractors and volunteers; training curriculum for volunteers who have contact with residents; and samples of training records for volunteers who have contact with residents. Although no contractors or volunteers are assigned specifically to this facility, records regarding a number of agencywide contractors and volunteers who might have occasion to enter the facility have been reviewed. Policy requirements for volunteer and contractor training is found in JJS Policies and Procedures PREA Compliance – Employee Preparedness (P.5.24A), right along with the requirements for employees to be trained. In addition to the training required to perform their duties, all must receive the basic training that employees receive.

Finding: AGRC is fully compliant with this Standard.

Standard 115.333: Resident education

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

115.333 (a)

- During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No

- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Is this information presented in an age-appropriate fashion? ☒ Yes ☐ No

115.333 (b)

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

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

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.333 (c)

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

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

115.333 (d)

- Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are deaf? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills? ☒ Yes ☐ No

115.333 (e)

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

115.333 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

AGRC residents receive information, at the time of intake, about the zero-tolerance policy, and about 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 documentation was provided to the Audit Team. JJS ensures that key information about its agency wide PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with Intake Staff and both residents. The Site Review. Agency policy governing PREA education of residents (Policy 5.24 B Section 4). Intake records of residents entering the facility in the past 12 months. Resident educational materials in formats accessible to those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to those who have limited reading skills. Logs and other records corroborating that those residents received comprehensive, age-appropriate PREA education, within 10 days of intake. Education and informational materials (posters, resident handbook, etc.) in compliance with the Standard.

Finding: AGRC is in full compliance with this Standard.

Standard 115.334: Specialized training: Investigations

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

115.334 (a)

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

115.334 (b)

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

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

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

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

115.334 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)
  ☒ Yes ☐ No ☐ NA

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

CYFD does do its own administrative, but not criminal, investigations. The State Police are 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 have agreements and training to help facilitate cooperation and efficient working relationships across the state. If law enforcement declines to investigate an allegation, said allegation gets investigated administratively. There is a Special Investigator under the Inspector General for CYFD who is assigned to cases of staff-on-resident misconduct. 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 Investigators completed the NIC training, "PREA: Investigating Sexual Abuse in a Confinement Setting."

Analysis: Evidence used to determine compliance with this Standard includes interview with Investigative staff; agency training policy for Investigative staff (Policy 5.4 A Section 6); Investigator training curriculum; and documentation that agency Investigators have completed required training.

Finding: AGRC complies fully with this Standard.

Standard 115.335: Specialized training: Medical and mental health care

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

115.335 (a)

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

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of

sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

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

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

115.335 (b)

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

115.335 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

115.335 (d)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

CYFD JJS has written policies related to the training of any 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, staff, including the PREA Coordinator, demonstrated an understanding of their responsibilities.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with Mental Health Staff; policy and procedures governing training of medical and mental health care practitioners around sexual abuse and sexual harassment (Policy 5.24 A Section 6); and documentation showing that mental health care practitioners have completed the required training.

Finding: AGRC complies fully with this Standard.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

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

115.341 (a)

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

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

115.341 (b)

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

115.341 (c)

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

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse? ☒ Yes ☐ No

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

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

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

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

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

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

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

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

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

115.341 (d)

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

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

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

115.341 (e)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

AGRC 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, both for risk of sexual victimization, and for 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 residents' 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 comes to their attention.

Analysis: Interviews were conducted with Risk Screening staff; with all residents; with the Agency PREA Coordinator; and with the Facility PREA Compliance Manager. The agency policy governing screening of residents, upon admission to a facility, or transfer to another facility, and during reassessments (Policy 5.24 B Section 5), was reviewed, along with related procedures. The screening instrument used to determine risk of victimization or abusiveness was reviewed. And records for residents admitted to the facility within the past 12 months were reviewed for evidence of appropriate screening within 72 hours.

Findings: AGRC complies fully with this Standard.

Standard 115.342: Use of screening information

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

115.342 (a)

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

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

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

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

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

115.342 (b)

- Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

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

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

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

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

115.342 (c)

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

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

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

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

115.342 (d)

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

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

115.342 (e)

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

115.342 (f)

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

115.342 (g)

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

115.342 (h)

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

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

115.342 (i)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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AGRC uses information from the risk screening required by ß115.341 to inform housing, bed, work, education, and program assignments. AGRC 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; and 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, using 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. At least twice a year, placement and programming assignments for each transgender or intersex resident shall be reassessed, to review any threats to safety experienced by the resident. Transgender or intersex residents' own views with respect to their own safety shall be given serious consideration. Transgender and intersex residents shall be given the opportunity to shower separately from other residents. With so few residents, there might often be times that no one known to identify as transgender or intersex is among residents. Also, there is always an administrator (someone who has access to all screening and assessment information) on call for after-hours emergencies.

Analysis: Interviews were conducted with the PREA Coordinator and with the Compliance Manager, Risk Screening Staff, and residents. Documentation was reviewed of the use of screening information to inform housing, bed, work, education, and program assignments, with the goal of keeping all residents safe and free from sexual abuse. Facility policies were reviewed (Policy 5.24 b Section 6. P.21 9-14, and 18). These auditing activities provided a triangulation of evidence of compliance with this Standard.

Findings: AGRC is in full compliance with this Standard.

REPORTING

Standard 115.351: Resident reporting

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

115.351 (a)

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

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

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

115.351 (b)

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

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

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

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

115.351 (c)

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

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

115.351 (d)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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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. 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 they 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; notify Medical or Behavioral Health (BH) Services; or write an anonymous letter to the PREA Reporting Office (POB 639, Las Cruces, NM 88004).

Analysis: Evidence used to determine compliance with this Standard includes: (1) Interviews with all of the following people: randomly selected staff; the PREA Compliance Manager; and residents. (2) Reviews of all of the following policies, documentation, and agreements: Policy 5.24C Sections 4.1 and 13; resident reporting brochures and materials; documentation on resident reporting; documentation of agreement with outside entity responsible for taking reports; staff training outlining procedures for staff to privately report sexual abuse and sexual harassment of residents; MOU with New Mexico D.O.C; MOU with Mexican Consulate; and verification of the audit team's test of the reporting system.

Finding: AGRC complies fully with this Standard.

Standard 115.352: Exhaustion of administrative remedies

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

115.352 (a)

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

115.352 (b)

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

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

115.352 (c)

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

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

115.352 (d)

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

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

- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension,

may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (e)

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

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

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

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

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

115.352 (f)

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

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

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

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

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

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

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

115.352 (g)

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

Auditor Overall Compliance Determination

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

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

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

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AGRC has an administrative procedure for dealing with resident grievances regarding sexual abuse. This policy is consistent with all the provisions of this Standard. For example, its 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, nor 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. CYFD has a policy that requires that all grievances be responded to within 5 days. Appeals are also responded to within 5 days, as well. 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.

Analysis: Evidence used to determine compliance with this Standard includes interviews with residents; grievance policy; resident grievances (none pertained to sexual abuse); policy and procedures for filing an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse; and policy limiting the agency's ability to discipline a resident for filing a grievance related to alleged sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith (cumulatively, Policy 5.24 C Section 5.1, P. 30.26 Section 9-10); and the Resident Handbook, to determine that relevant information is provided.

Finding: AGRC complies fully with this Standard.

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

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

115.353 (a)

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

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

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

115.353 (b)

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

115.353 (c)

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

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

115.353 (d)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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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, of 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. In addition to providing residents with reasonable and confidential access to their attorneys or other legal representation, AGRC also provides residents with reasonable access to parents or legal guardians. Interviews with staff and residents confirm a belief that outside support is available.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with residents, with the PREA Compliance Manager, and with the Superintendent; Policies and procedures governing resident access to outside victim advocates for emotional support services related to sexual abuse; Resident Handbooks; written materials prepared for residents, pertaining to reporting sexual abuse and access to support services; MOUs with community service providers who are able to provide residents with emotional support services related to sexual abuse; and policies governing residents' access to their attorneys, to other legal representation, and to parents or legal guardians (Policy 5.24B, Section 8). The Training Acknowledgement signed by each resident spell out the resident's ability to access outside support services and legal representation.

Finding: AGRC is in full compliance with this Standard.

Standard 115.354: Third-party reporting

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

115.354 (a)

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

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

Auditor Overall Compliance Determination

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

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

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

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CYFD 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 that 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 it provides methods whereby to report.

Analysis: Evidence used to determine compliance with this Standard includes: Publicly distributed information on how to report sexual abuse or sexual harassment on behalf of residents; the CYFD Website; PREA Posters; PREA Brochures.

Finding: AGRC complies fully with this Standard.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

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

115.361 (a)

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

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

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

115.361 (b)

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

115.361 (c)

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

115.361 (d)

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

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

115.361 (e)

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

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified? ☒ Yes ☐ No

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

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

115.361 (f)

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

Auditor Overall Compliance Determination

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

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

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

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

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. As mandated reporters, medical and mental health staff are required to inform residents, at the initiation of services, of their duty to report, and of the limitations of confidentiality. Upon receiving any allegation of sexual abuse, AGRC promptly reports the allegation to

the appropriate agency office; they also promptly report the allegation to the alleged victim's parents or legal guardians, unless the facility has official documentation showing the parents or legal guardians should not be notified. If the alleged victim is under the guardianship of the child welfare system, the report shall be made to the alleged victim's caseworker, rather than to her 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.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with randomly selected staff, with mental health staff, with the PREA Compliance Manager, and with the Superintendent. And relevant policy, governing the reporting by staff of incidents of sexual abuse or sexual harassment, and requiring all staff to comply with any applicable mandatory child abuse reporting laws: Policy 5.24 C Section 5.1; NM Stat § 32A-4-3 (2013). Also reviewed were the required checklists and forms, which remind staff and administrators of their roles with regard to specific reporting requirements.

Finding: AGRC is in full compliance with this Standard.

Standard 115.362: Agency protection duties

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

115.362 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

When the agency or the 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.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with the Agency Head, with the Superintendent, and with randomly selected staff; and relevant policy governing the agency's protection duties, when residents are subject to a substantial risk of imminent sexual abuse (Policy 5.24c, Sections 5.1 and 5.4). Response planning provided in training, and associated forms; both include reminders regarding this Standard.

Finding: AGRC is in full compliance with this Standard.

Standard 115.363: Reporting to other confinement facilities

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

115.363 (a)

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

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

115.363 (b)

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

115.363 (c)

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

115.363 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Upon receiving an allegation that a resident was sexually abused while confined at another facility, AGRC policy requires that its Director must notify the head of the facility, or the appropriate office of the agency or facility, where sexual abuse is alleged to have occurred, as soon as possible (but no later than 72 hours). Protective Services and law enforcement will also be contacted, as appropriate. 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 have been 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.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with the Agency Head and the Superintendent; Agency policy regarding reporting of allegations of sexual abuse of residents while confined at another facility; and Agency policy requiring that allegations of sexual abuse of residents received from other agencies or facilities are investigated in accordance with the PREA Standards (Policy 524B, Section 5.4). The CYFD JJS PREA Coordinator also tracks these allegations when they occur.

Finding: AGRC complies fully with this Standard.

Standard 115.364: Staff first responder duties

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

115.364 (a)

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

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

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth,

changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

115.364 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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 to 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: (a) 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; and (b) 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 ß115.361 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.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with residents; interviews with staff who would act as First Responders; and interviews with randomly selected staff, along with Agency policy governing staff First Responder duties (Policy 5.24 C Section 6). Also supporting compliance with this Standard is staff training materials and the Coordinated Response Plan.

Findings: AGRC is fully compliant with this Standard.

Standard 115.365: Coordinated response

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

115.365 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency has developed a written institutional plan to coordinate actions taken, among staff First Responders, any medical or mental health practitioners, Investigators, and facility leadership, in response to an incident of sexual abuse. This plan was provided to the Audit Team, and it was discussed during interviews with the Director, the PREA Coordinator, the PREA Compliance Manager, and others.

Analysis: Evidence used to determine compliance with this Standard includes: An interview with the Superintendent, and review of the Facility's Coordinated Response Plan and its CRP Check List. Staff First Responders, medical and mental health practitioners, and facility leadership were also asked questions regarding their level of understanding of the CRP. Also supporting compliance with this Standard is the interview with the representative of the Albuquerque SANE Collaborative.

Findings: AGRC complies fully with this Standard.

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

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

115.366 (a)

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

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency, facility, or other governmental entity responsible for collective bargaining on the agency's behalf has neither entered into, nor renewed, any collective bargaining agreement that restricts their ability to protect residents from abusers.

Analysis: Evidence used to determine compliance with this Standard includes: An interview with the Agency Head, and a review of the collective bargaining agreement with AFSCME. No information obtained during this Audit indicated any lack of ability to protect residents from abusers.

Finding: AGRC is in full compliance with this Standard.

Standard 115.367: Agency protection against retaliation

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

115.367 (a)

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

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

115.367 (b)

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

115.367 (c)

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

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

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

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

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

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

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

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

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

115.367 (d)

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

115.367 (e)

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

115.367 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency has a policy to protect all residents and staff who report sexual abuse or sexual harassment, or who cooperate with sexual abuse or sexual harassment investigations, from retaliation by other residents or staff. The agency designates specific staff with ensuring proper retaliation monitoring. The agency monitors the conduct or treatment of residents or staff who reported sexual abuse, and that 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 of such individuals for at least 90 days, and for longer, if needed; and it acts promptly to remedy any such retaliation. There have been no reports of retaliation in the past 12

months. AGRC's monitoring includes any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff.

Analysis: Evidence used to determine compliance with this Standard includes: (1) Interviews with each of the following: The Agency Head, the Superintendent, staff responsible for retaliation monitoring, and residents. (2) Agency policy protecting all residents and staff who report sexual abuse or sexual harassment, or who cooperate with sexual abuse or sexual harassment investigations, from retaliation by other residents or staff, including policies on the monitoring of residents and staff following a report, and the agency response to suspected retaliation (Policy 5.24 C Section 13). Also supporting compliance with this Standard were staff training materials, as well as the forms to be utilized in retaliation monitoring.

Finding: AGRC complies fully with this Standard.

Standard 115.368: Post-allegation protective custody

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

115.368 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

CYFD has a policy that residents who allege to have suffered sexual abuse may only be placed in Isolation as a last resort; however, AGRC, itself, does not have protective custody capacity. All residents have access to legally required educational programming, special education services, and daily large-muscle exercise.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with the Superintendent, staff, residents, and mental health staff; and a review of the Room Confinement Policy

(P.21.18 Room Confinement). No residents have been isolated or segregated for their protection, according to interviews conducted and reports reviewed. Since AGRC does not have Segregation, they would have to utilize room confinement protocols to temporarily approximate this type of protection.

Finding: AGRC is in full compliance with this Standard.

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

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

115.371 (a)

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

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

115.371 (b)

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

115.371 (c)

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

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

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

115.371 (d)

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

115.371 (e)

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

115.371 (f)

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

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

115.371 (g)

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

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

115.371 (h)

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

115.371 (i)

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

115.371 (j)

- Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention?
  ☒ Yes ☐ No

115.371 (k)

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

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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; it will not be determined by the person's status as resident or staff. No polygraphs are required. Investigations include an effort to determine whether staff actions or failures to act contributed to the abuse. Such investigations will be documented in written reports, which will include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. The departure of the alleged abuser or victim from the employment or control of the facility or agency will not provide a basis for terminating an investigation. When outside agencies investigate sexual abuse, the facility will cooperate with outside investigators and will endeavor to remain informed about the progress of the investigation.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with Investigative staff, with the Superintendent, with the PREA Coordinator, and with the Compliance Manager; Agency/Facility policies related to criminal and administrative agency investigations (Policy

5.24C Section 10); and Training records for Investigators. Since the facility had no investigations during the past year, the Auditor reviewed grievances filed. Although these grievances did not involve sexual abuse or sexual harassment, the documentation indicated investigative skill and compliance with policy.

Finding: AGRC complies fully with this Standard.

Standard 115.372: Evidentiary standard for administrative investigations

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

115.372 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

Analysis: Evidence used to determine compliance with this Standard includes: Agency/facility policy imposing a standard of a preponderance of the evidence or a lower standard of proof for determining whether allegations of sexual abuse or sexual harassment are substantiated (SAP03); interviews with Investigative staff; and documentation of administrative findings for proper standard of proof in agency investigations in prior years.

Finding: AGRC complies fully with this Standard.

Standard 115.373: Reporting to residents

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

115.373 (a)

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

115.373 (b)

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

115.373 (c)

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

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

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

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

115.373 (d)

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

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the

alleged abuser has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.373 (e)

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

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

JJS 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 AGRC residents during the past 12 months; so, the Audit Team did not have files to review to verify this practice. As such, compliance with this Standard was verified through interviewing administrators, and by reviewing policy and forms that would have been used. Also, notifications from previous years from other agency facilities were reviewed. Unless the agency/facility has determined that an allegation is unfounded, following a resident's allegation that a staff member has committed sexual abuse against the resident, the facility subsequently informs the resident 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 she 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.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with Superintendent and with Investigative staff; reviews of agency policies (Policy 5.24c. Sections 12.2-3); and reviews of documentation of notifications in previous years.

Finding: AGRC is in full compliance with this Standard.

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

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

115.376 (a)

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

115.376 (b)

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

115.376 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? ☒ Yes ☐ No

115.376 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Staff at AGRC 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 processes, as well as during 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.

Analysis: Evidence used to determine compliance with this Standard includes: Staff disciplinary policy regarding violations of Agency sexual abuse or sexual harassment policies (Policy 5.24A, Section 8.2). No allegations have been made during the more than 12 months reviewed for this audit; so, the Audit Team had no instances of staff discipline to review. Documentation provided to, and signed by, job applicants includes much of this Standard, and it is covered in the training curricula presented to new workers, as well.

Finding: AGRC complies fully with this Standard.

Standard 115.377: Corrective action for contractors and volunteers

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

115.377 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

115.377 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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 12 months reviewed for this audit, there were 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.

Analysis: Evidence used to determine compliance with this Standard includes: An interview with the Superintendent who supervises contractors/volunteers, and review of CYFD policy requiring 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 (Policy 5.24 A, Section 8.5-7). Contractor training materials were reviewed as well, and they provided information consistent with this Standard.

Finding: AGRC is in full compliance with this Standard.

Standard 115.378: Interventions and disciplinary sanctions for residents

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

115.378 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may

residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process? ☒ Yes ☐ No

115.378 (b)

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

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

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

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

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

115.378 (c)

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

115.378 (d)

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

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

115.378 (e)

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

115.378 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an

incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No

115.378 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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. AGRC is not a secure facility. It 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, and other interventions designed to address and correct the underlying reasons or motivations for abuse, and it 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 it deems such activity to constitute sexual abuse only if it determines that the activity is coerced. The Interim Report stated, "The recent addition of residents to the facility who are not under the authority of the juvenile justice system adds complexity to the ability to comply with 115.378 (b). According to interviews, youth under court order to comply with JJS may get different consequences for committing sexual abuse than other youth. The Standard requires that disciplinary sanctions be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories. Staff express confusion regarding what leverage they have with youth not in JJS custody, and indicate a need for guidance and policy regarding how to comply with this Standard in the imposing of sanctions in the

event a JJS youth and a CPS youth were involved in sexual abuse or sexual harassment. Policy appears to address this process for JJS youth, but not for CPS youth, in the absence of criminal proceedings."

Corrective Action: During the CAP, procedures were developed to address Standard 115.378 (Interventions and disciplinary sanctions for residents) so that all provisions of the Standard can be followed in the event of incidents of sexual abuse or sexual harassment by any residents at AGRC. The Deputy Director of Facilities and the Deputy Director of Field Services issued a Directive (20-004) clarifying that all youth placed in JJS facilities will be subject to the same protections and administrative expectations. It states, "For the purposes of PREA, all individuals (identified in JJS policy and procedure as clients) housed at JJS facilities/centers are afforded the protections of PREA and subject to its administrative expectations regardless of their CYFD-custody status." The Directive is being posted on the agency website with other policies and has been added to distribution and training lists. Due to precautions related to the COVID-19 Pandemic, the facility is not currently housing clients, therefore additional proof of implementation of the new directives is not required at this time.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with medical staff, mental health staff, investigators, and administrators; and a review of policies and directives. The documentation provided during the CAP was also reviewed, along with evidence of distribution and implementation. These documents and interviews provide a triangulation of evidence showing compliance with this Standard.

Finding: AGRC is in full compliance with this Standard.

MEDICAL AND MENTAL CARE

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

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

115.381 (a)

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

115.381 (b)

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

115.381 (c)

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

115.381 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

All residents at AGRC who have disclosed any prior sexual victimization during a screening pursuant to ß115.341 are offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. Numerous residents during the course of the past year disclosed prior victimization during screening, and they were appropriately offered a follow-up meeting with a mental health practitioner. All residents who have previously perpetrated sexual abuse, as indicated during the screening pursuant to ß 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; assignments to beds, work, education, and programs; and as otherwise required by federal, state, or local law.

Analysis: Evidence used to determine compliance with this Standard includes the following: Interviews were conducted with each of the following: resident(s) who discussed sexual victimization at Risk Screening; mental health staff; and staff who perform Risk Screening. Reviews were conducted of the following: the policy on medical and mental health screening (P.4.12, Sections 12 and 20); and a sample of medical and mental health secondary materials documenting compliance. It is also

noteworthy that, during training, data is provided to employees regarding the prevalence of prior sexual abuse among CYFD residents.

Finding: AGRC complies fully with this Standard.

Standard 115.382: Access to emergency medical and mental health services

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

115.382 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment? ☒ Yes ☐ No

115.382 (b)

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

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

115.382 (c)

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

115.382 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

According to JJS policy and interviews conducted, resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and to crisis intervention services. The nature and scope of such services are to be determined by medical and mental health practitioners, according to their professional judgment. Documentation by medical and mental health staff includes: the timeliness of emergency medical treatment and crisis intervention services provided; the appropriateness of the 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 (STI) prophylaxis. Resident victims of sexual abuse while incarcerated are offered timely information, about and timely access to, STI prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. If pregnancy were to occur in a resident due to sexual assault in the facility, the resident would be provided with all legally available information regarding appropriate medical services. 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.

Analysis: Evidence used to determine compliance with this Standard includes: Interviews with staff, including mental health staff, and with residents; and review of policies and procedures regarding access to treatment services by resident victims of sexual abuse (Policy 5.24B Section 9.1.and 9.2). The Audit Team has verified the availability of local emergency services consistent with the Coordinated Response Plan.

Finding: AGRC complies fully with this Standard.

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

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

115.383 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

115.383 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☒ Yes ☐ No

115.383 (c)

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

115.383 (d)

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

115.383 (e)

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

115.383 (f)

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

115.383 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

115.383 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

While AGRC offers medical and mental health evaluations to all residents, these services might not be offered onsite. They may be provided at other CYFD facilities, or in the community. This includes the provision of medical and mental health evaluations 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 that 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. If pregnancy were to occur in a resident due to sexual assault in the facility, the resident would be provided with all legally available information regarding appropriate medical services.

Analysis: Evidence used to determine compliance with this Standard includes: interviews with staff, including mental health staff, and interviews with residents; and review of policies and procedures governing ongoing medical and mental health care for sexual abuse victims and abusers (Policy 5.24b Section 8.7). Interviews with agency administrators and with community providers also indicate compliance with this Standard.

Finding: AGRC complies fully with this Standard.

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

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

115.386 (a)

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

115.386 (b)

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

115.386 (c)

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

115.386 (d)

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

115.386 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

According to policy, AGRC 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 the 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 they will allow for input from line supervisors, investigators, and medical or mental health practitioners. The Incident 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 then the Team submits their report to the facility head and to the PREA Compliance Manager.

Analysis: Evidence used to determine compliance with this Standard includes: interviews with the Superintendent, with the PREA Compliance Manager, and with the Incident Review Team; and policies and procedures on conducting sexual abuse Incident Reviews (Policy 5.24c Section11).

Finding: AGRC complies fully with this Standard.

Standard 115.387: Data collection

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

115.387 (a)

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

115.387 (b)

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

115.387 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

115.387 (d)

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

115.387 (e)

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

115.387 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The CYFD JJS PREA Coordinator, the JJS Performance/Policy Bureau Chief, the AGRC Superintendent, and the AGRC PREA Compliance Manager verify that AGRC 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.

Analysis: Evidence used to determine compliance with this Standard includes: the policy regarding sexual abuse data collection; the set of definitions used for collecting data on sexual abuse allegations at facilities (Policy 8.14.23. Pages 1, 8, 14, 23); the data collection instrument used for collecting data on sexual abuse allegations at facilities (AGRC PREA Investigation Log 2019); and the ADE Software Guide.

Findings: The AGRC complies fully with this Standard.

Standard 115.388: Data review for corrective action

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

115.388 (a)

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

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

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

115.388 (b)

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

115.388 (c)

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

115.388 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

Data collected and aggregated pursuant to ß115.387 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 it provides an assessment of the agency's progress at each facility, as well as that of the whole agency. 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.

Analysis: Evidence used to determine compliance with this Standard includes: interviews with the Agency Head, with the PREA Coordinator, and with the Compliance Manager, and the link to the website where the Annual Report is available.

Finding: AGRC complies fully with this Standard.

Standard 115.389: Data storage, publication, and destruction

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

115.389 (a)

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

115.389 (b)

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

115.389 (c)

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

115.389 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

CYFD ensures that incident-based and aggregated data are securely retained, and it requires that aggregated sexual abuse data be 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.

Analysis: Evidence used to determine compliance with this Standard includes: Interview with PREA Coordinator; Directives; website; and policy: 1.13.3 NMAC Records Retention and Security (Sections 1.13.10 B & 1.13.3.11 A1).

Finding: AGRC is in full compliance with this Standard.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

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

115.401 (a)

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

115.401 (b)

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

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

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

115.401 (h)

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

115.401 (i)

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

115.401 (m)

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

115.401 (n)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

This is the first year of the audit cycle. The agency is on track to continue having all its facilities audited in a timely manner, as it did in its previous audit cycle.

Analysis: CYFD has demonstrated compliance with this Standard by auditing all its facilities. All the PREA Audit Final Reports indicate full compliance with this PREA Standard.

Finding: The agency has shown compliance with this Standard.

Standard 115.403: Audit contents and findings

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

115.403 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

CYFD maintains an accessible and searchable website. The PREA Audit Final Reports can be found at: https://cyfd.org/facilities/prison-rape-elimination-act-prea.

Analysis: The agency publishes the PREA Audit Final Reports on the same page as the PREA reporting instructions, PREA policies, advocacy resources, and annual reports.

Finding: The agency is compliant with this Standard.

AUDITOR CERTIFICATION

I certify that:

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

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

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

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

D. Will Weir 07-30-2020

Auditor Signature **Date**

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.