PREA AUDIT REPORT ☐ INTERIM ☒ FINAL
JUVENILE FACILITIES

Date of report: 09/18/2016

Auditor Information			
Auditor name: Bernadette Powe			
Address: 8083 Holtville Road, Wetumpka, AL 36092			
Email: bpowe@hotmail.com			
Telephone number: 334-339-2804			
Date of facility visit: August 13, 2016			
Facility Information			
Facility name: Perrry Varner Educational and Training Facility			
Facility physical address: 1002 Selfield Road, Selma, AL 36703			
Facility mailing address: *(if different from above)* same			
Facility telephone number: 334-876-4814			
The facility is:	☐ Federal	☐ State	☒ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☐ Correctional	☐ Detention	☐ Other
Name of facility's Chief Executive Officer: Marcus Hannah			
Number of staff assigned to the facility in the last 12 months: 23			
Designed facility capacity: 32			
Current population of facility: 6			
Facility security levels/inmate custody levels: Minimum			
Age range of the population: 12 -17			
Name of PREA Compliance Manager: Tanika Brown		**Title:** Office Manager	
Email address: tanikanbrown@gmail.com		**Telephone number:** 334-877-0629	
Agency Information			
Name of agency: same			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: same			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: same			
Agency Chief Executive Officer			
Name: Marcus Hannah		**Title:** Director	
Email address: marcushannah@att.net		**Telephone number:** 334-876-4814	
Agency-Wide PREA Coordinator			
Name: Kimberly Bonner		**Title:** Assistant Administrator	
Email address: kcbonner@outlook.com		**Telephone number:** 334-877-0639	

AUDIT FINDINGS

NARRATIVE

The Prison Rape Elimination Act (PREA) on-site audit for the Perry Varner Educational and Treatment Faciltiy was conducted on August 13, 2016 , in Selma, AL. The audit was conducted to determine compliance with the Prison Rape Elimination Act (2003) and its' standards for zero tolerance of sexual abuse in juvenile correctional and residential facilities. Please refer to the National PREA Resource Center site at prearesourcecenter.org for further information. The audit was conducted by Bernadette Powe and Christy Vincent, United States Department of Justice (DOJ) PREA certified juvenile and adult facilities auditors, respectively.

The Perry Varner Educational and Treatment Facility was founded in 2000 as a wilderness program by the approval of the Dallas County Commission. It was named after Perry Varner, a former Dallas County Commissioner dedicated to help wayward youth in Dallas County. Perry Varner is a residential treatment facility that receives males between the ages of 12 – 17 from the Juvenile Courts of Dallas, Perry, Wilcox, Hale, Lowndes, Marengo and Bibb Counties. The youth are referred to this facility for a minimum of eight (8) weeks to receive treatment and training for their problems they encounter in their communities. Camp Perry Varner goals and objectives is to develop and enhance positive behavior characteristics in delinquent youth through counseling which includes self-concept development, anger management, goal settings, academics, and physical fitness components in a highly structured intensive program. Also to decrease the number of referrals to the Department of Youth Services and to reduce the recidivism rate of the Juvenile Courts in the counties they serve.

The Perry Varner Educational and Treatment Facility is a 32-bed facility for males only. It has 8 sets of 4 open-dormitory style living areas that are observed by direct staff, no cameras exist in these areas. The males do not dress or undress in these areas only in the designated areas (shower area). The current population at the time of the PREA audit was six (6) males. The average length of stay for a juvenile is eight (8) weeks. The facility has several staff offices, a central control room with state of the art camera/video surveillance. The Perry Varner Educational Treatment facility has an intake area, laundry areas, visitation area, showers, a separate building utilized as a multi purpose building, dining, recreational time, etc., and classroom. The juveniles serviced here utilize the same medical staff as the youths at the Dallas County Juvenile Detention Center. The Perry Varner Facility is on the same campus of the Dallas County Juvenile Detention Center. It is separated by a locked covered fence. The juveniles cannot see each other beyond the fence on either side.

The audit process consisted of a review of the agency and facility. The pre-audit preparation included a thorough review of all documentation and material submitted by the agency and facility along with data included in the completed Pre-Audit Questionnaire. The auditor received primary documentation which consisted of policy and secondary documentation via email for prior to and after the on-site phase of the audit process. The documentation reviewed also consisted of agency and facility policies, procedures, forms, education materials, training curriculum, organization charts, posters, brochures, quarterly reports, inmate population reports, memorandums of agreement, signed training rosters, community-based contact information, facility schematic, and other Prison Rape Elimination Act related materials that were provided to demonstrate compliance with the Prison Rape Elimination Act standards.

During the review of material the auditor and The Perry Varner Educational and Treatment Facility PREA Coordinator and PREA Manager worked diligently to obtain all material necessary to meet the standards for PREA compliance. Communication and teamwork was key in this process from the auditor and the PREA Coordinator (Ms. Bonner) and PREA Manager (Ms. Brown). Answers to the questions were submitted by the agency Prison Rape Elimination Act Coordinator and facility Prison Rape Elimination Act Compliance Manager and reviewed by the auditor prior to and after the on-site phase of the audit process.

The auditor (Ms. Powe) met the Coordinator and Manager upon arrival for the on-site portion of the audit. The auditor was allowed access to the agency and facility in order to conduct the audit (tour and interviews). After the initial meeting the audit toured the facility accompanied by the PREA Coordinator, PREA Manager as well as other supervisory staff. The auditor contact information was posted throughout the facility prior to the on-site phase of the audit, dated July 6, 2016 containing

contact information for the lead auditor. The facility staff and juveniles were fully cooperative with the auditor and audit process.

A schematic layout of the facility was provided prior to the audit. A list of staff, volunteers, and contractors to include assignments and roles was provided to the auditor along with listings by dormitory for a random and objective selection of inmates for interviews.

The auditor reviewed compliance with the Prison Rape Elimination Act standards based on a review of agency policy, procedure, practice, daily activities, documentation, observation, and interviews with staff and juveniles. Interviews were conducted with the Director of the Facility, PREA Coordinator, PREA Manager, Human Resources, the nurse and other pertinent personnel and/or agencies. The agency has a memorandum of agreement with an outside agency victim advocacy (Family Sunshine Center) service available at no cost and confidential for the juveniles at 334-399-1451. They also have a crisis hotline STAR (Standing Together Against Rape) Crisis Hotline at 888-908-7273.

Juveniles and staff were interviewed using the recommended Department of Justice protocols that question their knowledge of the Prison Rape Elimination Act protections specifically their knowledge of what the Prison Rape Elimination Act is and what is its' purpose. This included questioning that was included but not limited to: purpose, meaning, protections provided by the act, how to report (methods available for reporting), when to report, rights, responsibilities, etc.

Staff was questioned using the Department of Justice protocols that questioned their Prison Rape Elimination Act training and overall knowledge of the agency's and facility's zero tolerance policy, reporting mechanisms available to inmates and staff, the response protocols when an inmate alleges abuse, and first responder duties. The Director, PREA Coordinator, PREA Manager, Human Resources and the nurse were interviewed intentionally, after those individuals were interviewed a random sampling of staff and juveniles were selected from lists presented to the auditor by the facility. Individuals were were randomly selected by the auditor from the lists provided for staff on duty (which included all shifts) and residents in the facility at the time of the audit. A total of nine agency and facility staff were interviewed per random sampling from the auditor. A total of 4 juveniles were interviewed per random sampling from the auditor. Staff were available from all three shifts that were included in the interviews.

An exit interview was conducted at the end of the on-site visit by the auditor with the PREA Coordinator and the PREA Manager. There were no reported allegations of sexual abuse, harassment, or assault during this audit period (12 months).

Recommentations were made by the auditor to the facility PREA Coordinator and PREA Manager to complete within 20 days to be fully compliant with PREA standards. Those suggestions included: ensure screening for risk of victimation and abusiveness is documented for every individual that enters the facility, correct wording of handbook regarding each facility, signs that state staff only in several areas (technology building and kitchen area), provide non-occurrence statements, include PREA signs in Spanish as well, secure staff bathrooms and closets with locks, provide investigator certification(s), revise Staffing Plan.

The listed recommendations were completed and provided to the auditor.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Perry Varner Educational and Treatment Facility is a 32-bed facility for males only. It has 8 sets of 4 open-dormitory style living areas that are observed by direct staff, no cameras exist in these areas. The males do not dress or undress in these areas only in the designated areas (shower area). The current population at the time of the PREA audit was six (6) males. The average length of stay for a juvenile is eight (8) weeks. The facility has several staff offices, a central control room with state of the art camera/video surveillance. The Perry Varner Educational Treatment facility has an intake area, laundry areas, visitation area, showers, a separate building utilized as a multi purpose building, dining, recreational time, etc., and classroom. The juveniles serviced here utilize the same medical staff as the youths at the Dallas County Juvenile Detention Center. The Perry Varner Facility is in the same campus of the Dallas County Juvenile Detention Center. It is separated by a locked covered fence. The juveniles cannot see each other beyond the fence on either side.

SUMMARY OF AUDIT FINDINGS

The Perry Varner Educational and Treatment Facility is a county residential facility in reference to Prison Rape Elimination Act standard compliance under juvenile residential facilities and the audit process. The pre-audit preparation included a thorough review of all primary/policy and secondary/practice documentation and materials submitted by the agency and facility along with the data included in the completed Pre-Audit Questionnaire to demonstrate compliance with the standards. The auditor was impressed with the documentation submitted, however worked with the facility to receive all documentation to meet or exceed PREA standards.

The auditor conducted a thorough facility-wide audit. No sexual assault, abuse and/or harassment allegations were reported during the past 12 month period from the date of the audit. The auditor received no inquiries or requests for an interview during the audit process or inquiries from the auditor posted contact information. Juveniles were able to articulate to the auditor what they would do and who they would tell if they were sexually abused. The auditor was impressed with the PREA information stations that were set up throughout the facility, including visitation areas. The auditor was also impressed that a PREA video was shown every morning prior to starting class to all the juveniles. Several of the juveniles made the comment they were "tired of watching it" but felt it helped them to learn and retain information on PREA. All facility staff interviewed indicated they had received detailed Prison Rape Elimination Act training and could articulate the meaning of the agency's zero tolerance policy.

The juveniles complimented the facility and staff for creating and implementing what some considered an open environment where the staff is approachable and they are responsive to their needs to include reporting PREA violations if needed. The staff has done an excellent job creating a zero tolerance environment and an environment were the juveniles are not afraid to report violations of PREA.The auditor was very impressed with the extensive facility camera and video monitoring system that was installed.

The staff and juveniles were completely cooperative and helpful throughout the audit process. The agency and facility staff did a good job of providing the auditor with primary and secondary documentation to confirm compliance with the Prison Rape Elimination Act standards. The auditor noted that this audit is the first initial PREA audit for the facility, staff, and juveniles. The auditor stressed the importance of maintaining compliance as well as conducting follow-up reviews by agency and facility leadership during the exit briefing. The auditor has determined that the facility is 100% compliant with the Prison Rape Elimination Act standards for this review period.

In addition, the auditor determined that the facility exceeds standard four (4) standards: 115.313; 115.318; 115.333; 115.354.

Number of standards exceeded: 4

Number of standards met: 37

Number of standards not met: 0

Number of standards not applicable: 0

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency regulation and facility policy (13.8.1) mandates a zero tolerance policy and an implementation plan is in place outlining how the agency and facility will implement the zero-tolerance approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The agency and facility has an easy to understand organizational chart and the auditor was provided a copy during the pre-audit phase of the audit. The facility staff acknowledged an understanding of the zero tolerance policy.

Interview of staff and juveniles during the audit process indicated their understanding of PREA's zero tolerance policy, facility layout, camera system, information posted and staff knowledge and zero incidents indicated their understanding of policy.

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Agency policy (13.8.1) contains the necessary wording/language to address the requirement of adding PREA language and ensuring that all contractors understands the requirement. Memorandum of Agreement with the Montgomery County Detention Facility. Interviews with agency Prison Rape Elimination Act Coordinator and facility Compliance Manager and documentation of training and credentials. Pre-Audit Questionnaire.

Standard 115.313 Supervision and monitoring

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

The auditor interviewed the facility Director as well as PREA Coordinator and the PREA Manager and verified that the staff develops, implements, and documents a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. The facility takes the following into consideration per the standard:

*DYS Policy 13.8.1
*Staff to resident ratio 1:8 (day) and 1:12 (night)
*The composition of the inmate population;
*The number and placement of supervisory staff;
* Institution programs occurring on a particular shift;
*The facility's deployment of video monitoring systems and other monitoring technologies
*The resources the facility has available to commit to ensure adequate staffing levels

The staff did not deviate from the above staffing plans or ratio for this audit period. The facility receives an exceed due to the staffing plan, number of staff on duty far exceeds the ratio required by standard. The monitoring system is a state of the art monitoring system with no visible blind spots.

Standard 115.315 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to verify compliance with the above listed standard:
*Interviews with staff and residents.
*DYS Policy 13.8.1
*DYS Agency Policy 13.14
*DYS Agency Policy 9.10
*Facility Policy

There are no cross gender searches of residents by staff. Interviews with residents and staff substantiated policy prohibiting staff from conducting cross gender search or physically examing a transgender or intersex resident for the sole purpose of determining the residents genital status. No persons of this nature were admitted during this audit period to the facility.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

The following were utilized to verify compliance with the above standard:

There have been zero instances where the services of an interpreter was needed during the current audit period. The center has an agreement with the Dallas County local school Board to ensure effective communication with residents with LES (Limited English Proficiency). At no time are other residents allowed to serve as interpreters for residents. Interviews with residents substantiated the facility does practice using residents as there were no instances to reference.

Standard 115.317 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was used in determining compliance with the above standard:
*DYS Policy 13.18.1
*Interviews with staff (Human Resources, Director, PREA Coordinator, PREA Manager).
*Per interview with Human Resources all new staff have criminal backgrounds checks conducted to include Alabama Bureau of Investigation and C/AN (Child Abuse and Neglect) Reports.
*Twenty-three people were assigned to the facility in the past twelve months. File Reviews indicated background check was conducted on all employees.

Standard 115.318 Upgrades to facilities and technologies

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to determine exceeding the above standard:
The facility utilizes a state of the art monitoring system; the system monitors are of the best quality I have seen in a youth facility, there are no blind spots in any area. The large monitors allow for clear viewing.

Standard 115.321 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was used to verify compliance with the above listed standard:
*DYS Agency Policy 13.18.1

*The facility does not conduct its own investigations of sexual abuse of harassment. Investigations are conducted by the Dallas County Department of Human Resources/law enforcement per policy. The Dalls County Sheriffs Department has a Sexual Assault investigator on call 24/7 (John Treherne) who conducts all allegations of sexual abuse. The facility has an MOU on file with the Dalls County Sheriffs Deparment. All forensic are completed by the local hospital (Vaughan Regional Medical Center, Selma, AL) at no cost to the residents the residents are taken through the emergency room as outlined in the policy. The facility has a MOU on file with the Sunshine Center (Victim Advocate/Rape Crisis Center).

*There have been no incidents of sexual allegations during this audit period.

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was used to determine compliance with the above listed standard:

*DYS Agency Policy 13.8.1
The PREA policy, interviews with staff (Director, PREA Coordinator, PREA Manager) ensures that the facility will refer all allegations of abuse to the Dallas County Department of Human Resources. The policy requires cooperation by the facility in such cases. There have been no instances of sexual harassment, assault, abuse or allegations during this audit period.

Standard 115.331 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

The following information was utilized to determine compliance with the above standard:

*DYS Policy 13.18.1
*Policy, Staff training records, and staff interviews revealed staff has received and continues to receive PREA training. Staff understands the procedures for as a first responder as indicated in interviews, they understand zero tolerance regarding PREA. Employee training records were provided to verify compliance as well.

Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to determine compliance with the above standard:

*DYS Policy 13.18.1

*Policy requires volunteers and contractors who have contact with residents to receive PREA training based on the services they provide and contact with the residents. The facility has no volunteers. Contract staff signs documentation acknowledging that they understand PREA its' zero tolerance for sexual abuse.

Standard 115.333 Resident education

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to erify compliance with the above standard:

*DYS Agency Policy 13.18.1
*Residents receive PREA Orientation upon entering the facility. Residents are administered the sexual assault survey upon entry into facility (please note this was corrected during the audit as the facility were not tracking paper copies). However the students viewed a video daily prior to beginning class on PREA. The facility has several "PREA Stations" located through out the facility for anyone who visits the facility (parents, etc.)
*Interviews with the residents indicated they were extremely knowledgable regarding PREA and zero tolerance. The residents indicate they felt safe while at the facility. They also indicated they felt safe in reporting any problems including PREA violations to staff.

Standard 115.334 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to verify compliance with the above standard:

The PREA Coordinator for the facility has been trained to conduct administrative investigation. PER MOU's on file and proved investigations are conducted by the Department of Human Resources and the local Dallas County Sheriffs Department.

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information ws utilized to verify compliance with the above standard:

The facility does employ full-time medical staff and contracts for mental health staff. Credentials were verified.
The auditor interviewed the medical staff and staff with the Sunshine Center.

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to determine compliance with the above standard:

*Resident receive screening upon entering facility (Sexual Victimization Survey).
*Resident interviews indicated screenings were being conducted upon entering facility.

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to determine compliance with the above standard:

*DYS Policy 13.18.1

*The facility has 8 sets of 4 bed dormitories (boys only program). Victimization may determine placement of residents at risk closer to staff in the housing unit.

*Residents are not housed separately based on their LGBT status. This information was verified through staff interviews.

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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The following was utilized to determine compliance with the above standard:

*DYS Policy 13.18.1

*The facility follows policy regarding providing multiple ways the resident can report sexual abuse and harassment.
*During interviews the residents advised the auditor of ways they could report sexual abuse/harassment: Complaint box, staff member, hotline, PREA Coordinator, parent, information from posters posted with toll-free numbers and local numbers to report. Residents' handbook contains information on PREA and how to report it. Residents advised they are able to make private calls when requesting to report sexual allegations.
*Staff interviews indicated they are knowledgable in allowing residents to male private calls from the nurses station (most private space in the facility).

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to determine compliance with this standard:

*DYS Policy 13.18.1

The facility does have administrative procedures for handling resident grievances regarding sexual allegations. Residents may place written grievances regarding sexual allegations in a complaint box; the PREA Coordinator and Manager may receive written grievances from residents regarding sexual assault.

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was used to determine compliance with above standard:

*DYS Policy 13.8.1
*The facility follows policy by having MOU's on file with outside agencies that can provide support to residens confidentially if reporting sexual allegations. The facility has access to the Sunshine Cemter and STAR (Standing together Against Rape) hotlines. Both provide mental health support as well as forensic interviews and are with the resident throughout the process.
*Per interviews with the staff, resident and centers no instances have been reported during this audit period.

Standard 115.354 Third-party reporting

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to determine compliance with the above standard:

*DYS Policy 13.8.1
*The DYS website provides the public with information regarding third party reporting of abuse. Also the PREA Stations located throughout the facility provide visitors with information regarding report PREA violations.
*Resident interviews revealed they were knowledgable in third-party reporting. They advised their parents could report it, they could notify their Probation Officers, they would write letters, etc.
*Posters posted regarding reporting were posted throughout the facility.

Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to determine compliance with the above standard:

DYS Policy 13.8.1

Interviews with staff indicated their knowledge as staff and agency reporting duties. Staff is required to immediately report any allegations of sexual abuse, suspicion of or information they receive indication such. Random interviewing of staff indicated further compliance with the above standard.

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to determine compliance with this standard:

*DYS Policy 13.18.1

*Policy requires that immediate action is taken upon learning that a resident is subject to a substantial risk of imminent sexual abuse.
*Interviews with resident determined that no residents were at risk for sexual assault/abuse during the audit period.
*Interviews with staff, PREA Coordinator and PREA Manager substantiated compliance with this standard.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following was utilized to determine compliance with the above standard:

*DYS Policy 13.18.1
*Policy requires the receiving facility to notify the other agency upon learning of abuse alleged by a resident entering the facility from a previous facility within 72 hours. Interviews with supervisory staff (PREA Coordinator and Manager) advised the other agency would be notified immediately. There were no instances of such allegations during this audit period.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following was utilized to determine compliance with the above standard:

DYS Policy 13.8.1

Per Policy and interviews with random staff, staff indicated that upon learning of an allegation that a resident was sexually abused, the first staff member to respond to the report shall: separate the alleged victim and abuser; 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, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, drinking, or eating; and if the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions identical to the actions of the victim.

Standard 115.365 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following were utilized to determine compliance with the above standard:

DYS Policy 13.18.1

The facility has a written facility plan to coordinate actions in response to an incident of sexual assault among staff. Interviews with staff advised they are to immediate notify the PREA Coordinator and Manager of any allegations of sexual abuse.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following were utilized to determine compliance with the above listed standard:

The facility is not a collective bargaining agency. The facility Director/designee, PREA Coordinator, PREA Manager and staff shall ensure the alleged victim and the aggressor are physically separated.

Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized in determining compliance with the above listed standard:

*DYS Policy 13.18.1

*Policy and the facility requires the monitoring of residents and staff who have reported sexual allegations or who have cooperated in a sexual allegations investigation. The monitoring of individuals shall take place for a period of 90 days or longer as needed. PREA Coordinators and Managers are charged with monitoring for possible retaliation. There were no instances of sexual allegations reported.

Standard 115.368 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to determine compliance with the above standard:

*DYS Policy 13.18.1
Policy and facility provide guidelines for the use of room restriction as a last measure to keep residents who alleged sexual abuse safe and then only until alternative means for keeping the resident safe can be arranged. No instances requiring such occurred during this audit period.

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to determine compliance with the above standard:

*DYS Polocy 13.8.1
*Administrative/criminal investigations for the facility are conducted by the Department of Human Resources and the Dallas County Sheriff Department per policy. There were no investigations of sexual assault during this audit period.

Standard 115.372 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

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

The following was utilized to determine compliance with the above standard:

*DYS Policy 13.18.1
*Rules and Regulations state that facilities shall impose no standard higher that preponderance of the evidence in determining whether allegations of sexual abuse/harassment are substantiated.

Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to determine compliance with the above standard:

*DYS Policy 13.18.1

*Policy indicated the process for notifying residents whether allegations of abuse were substantiated, unsubstantiated or unfounded. The PREA Coordinator and PREA Manager indicated their knowledge of this during their interview. No such instances occurred during this audit period.

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

*DYS Policy 13.18.1
*Policy requires staff disciplinary sanctions up to and including termination for violating facility sexual abuse harassment policy. The policy mandates that the violation be reported to law enforcement and any licensing entities. No such occurences occurred during this audit period.

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

*DYS Policy 13.18.1
*Policy requires that volunteers and contractors who engage in sexual abuse shall be prohibited from contact with juveniles. The policy mandates that the violation be reported to law enforcement and any licensing entities. No such occurences occurred during this audit period.

Standard 115.378 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to determine compliance with the above standard:

*DYS Policy 13.8.1
*Policy states the facility shall consider whether to offer the offending juvenile participation in therapy, counseling or other interventions designed to address and correct underlying reasons or motivations for the abuse. There were no such occurrences during this audit period.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to determine compliance with the above standard:

*DYS Policy 13.8.1
*Juveniles identified as high risk with a history of assaultive and/or predatory behavior, or at risk for sexual victimization shall be identified,

monitored, counseled, and provided treatment deemed appropriate by the facility contracted mental health professional. Staff shall ensure that the juvenile is offered a follow-up meeting with a medical or mental health practioner within 14 days of the intake screening.

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to determine compliance with the above standard:

*DYS Policy 13.8.1
*Policy requires timely access to emergency, medical treatment and crisis intervention services for victims of sexual abuse. There were no instances of sexual abuse reported during this audit period.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to determine compliance with the above standard:

*DYS Policy 13.8.1
*Policy requires ongoing medical and mental health care for sexual abuse victims. The facility shall provide medical and mental health evaluations and appropriate follow-up treatment. Victims of sexual abuse will be transported to the local ER where they will receive treatment and where physical evidence can be gathered. There have been no sexual assault victims in this reporting period; however, if needed procedures are in place.

Standard 115.386 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to determine compliance with the above standard:

*DYS Policy 13.8.1
*There have been no investigations of sexual abuse at the facility. Facility writtern institutional plan outlines protocol for review which shall occur within 30 days of the conclusion of the investigation.

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to determine compliance with the above standard:

*DYS Policy 13.8.1
*Policy requires facilities to maintain review and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. When requested this information shall be submitted to DYS PREA Coordinator as outlined in facility institutional plan.

Standard 115.388 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to determine compliance with the above standard:

*DYS Policy 13.8.1
*Policy requires facilities to review data for corrective action to improve its effectiveness of its prevention, detection and response practices and training. There have been no sexual allegations of abuse.

Standard 115.389 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The following information was utilized to determine compliance with the above standard:

*DYS Policy 13.8.1
*Policy requires facilities to securely retain data for ten (10) years.

AUDITOR CERTIFICATION
I certify that:

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

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

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

Click here to enter text. Click here to enter text.

Auditor Signature Date