PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: March 1, 2017

Auditor Information			
Auditor name: Elaine Bridschge			
Address: P.O. Box 66 Valley Farms, AZ 85191			
Email: ebridsch@courts.az.gov			
Telephone number: 520-866-7074			
Date of facility visit: October 3-5, 2016			
Facility Information			
Facility name: Pima County Juvenile Court Center			
Facility physical address: 2225 East Ajo Way Tucson, AZ 84713			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 520-724-2150			
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: Jennifer Torchia			
Number of staff assigned to the facility in the last 12 months: 124			
Designed facility capacity: 55			
Current population of facility: 45			
Facility security levels/inmate custody levels: Secure			
Age range of the population: 11-17			
Name of PREA Compliance Manager: N/A		**Title:** N/A	
Email address: N/A		**Telephone number:** N/A	
Agency Information			
Name of agency: Pima County Juvenile Court Center			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 2225 East Ajo Way Tucson, AZ 84713			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 520-724-2150			
Agency Chief Executive Officer			
Name: Jennifer Torchia		**Title:** Division Director Detention Services	
Email address: jennifer.torchia@pcjcc.pima.gov		**Telephone number:** 520-724-5005	
Agency-Wide PREA Coordinator			
Name: Ramona Panas		**Title:** PREA Coordinator	
Email address: Ramona.panas@pcjcc.pima.gov		**Telephone number:** 520-724-9874	

AUDIT FINDINGS

NARRATIVE

The PREA onsite audit of the Pima County Juvenile Court Center (PCJCC) in Tucson Arizona was conducted on October 3rd , 4th , and 5th , 2016 by Elaine Bridschge, from Valley Farms, Arizona, a U.S. Department of Justice Certified PREA Auditor for Juvenile Facilities. The purpose of the audit was to determine the degree of compliance with the Federal Rape Elimination Act (PREA) standards.

Six weeks in advance of the onsite audit, the auditor provided the PREA Coordinator with a flyer to be posted throughout the facility announcing the upcoming audit. The flyer explained the purpose of the audit and provided residents and staff with the auditors contact information. The Facility dated the flyer with the date when it was posted and submitted a photo to the Auditor.

Pre-audit preparation included a thorough evaluation of all documentation and materials electronically submitted by the facility along with the data included in the pre-audit questionnaire. The documentation reviewed included agency policies, procedures, forms, education materials, training curriculum and rosters, organizational chart, posters, brochures, and other relevant materials that were provided to determine compliance with the PREA standards. This review prompted a series of questions that were submitted to the PREA Coordinator for review and clarification. Responses were submitted by the PREA Coordinator in a timely manner and reviewed by the auditor prior to the onsite audit. Additional documentation was also requested by the auditor and submitted to the PREA Coordinator. The PREA Coordinator submitted the additional documentation which was also reviewed by the auditor.

The onsite portion of the audit was conducted over a three day period: October 3rd, 4th, and 5th, 2016. During this time, the auditor conducted interviews with facility leadership, staff, and residents. The interviews were conducted consistent with Department of Justice PREA auditing expectations in content and approach utilizing the PREA Compliance Audit Instrument Interview Guides, as well as individuals selected for interviews (i.e. Facility Director, PREA Coordinator, specialized staff, random staff, residents, etc.). The auditor was able to ask additional questions to personnel to gain more information about certain practices of the facility. In addition, the auditor was able to verify through interviews specific protocols and clarify documentation submitted.

An extensive facility tour was conducted which included observation of facility configuration, staff supervision of residents, housing, intake, classrooms, medical unit, visitation area, master control room, recreation areas, and administration areas. The auditor was able to view camera locations, showering areas, toilet facilities, and sleeping rooms. The auditor was able to informally talk to the residents, staff, and the master control officer. While on the tour, the auditor was permitted access to all areas of the facility. Notices of the PREA audit were observed posted in each of the five housing units. The auditor was escorted by the PREA Coordinator.

Forty five residents were identified on the facility roster as being detained. The auditor was able to interview fifteen or 33% of residents. The residents were selected randomly by the auditor using a current roster of residents. The auditor selected a minimum of three from each of the five housing units, and a minimum of one from each gender. At the time of the onsite visit, there were no residents to interview that met the criteria for residents who reported a sexual abuse, residents in isolation, residents who disclosed prior sexual victimization during risk screening, residents who were disabled or spoke a language other than English, or transgendered, intersex, gay, lesbian, and bisexual residents. Residents were interviewed using the recommended DOJ PREA Compliance Audit Instrument Interview Guides that question their knowledge of a variety of PREA protections generally and specifically their knowledge of reporting mechanisms available to residents to report abuse and harassment. The auditor was able to ask additional questions to residents to gain more information about certain practices of the facility. In addition, the auditor was able to gather information through interviews regarding facility practices that occur in the environment.

Nineteen facility staff members were interviewed representing all three shifts (days, swings, and graves). The Auditor selected staff randomly and by specialty using a current staff roster. The Auditor randomly selected at a minimum: two officers per shift, one officer of each gender, one medical staff involved in cross-gender strip or visual searches, one security staff who has acted as first responder, one intake officer, one master control officer, 2 lead officers, 2 supervisors, and one non-security staff who had acted as a first responder. Staff were questioned using the recommended DOJ PREA Compliance Audit Instrument Interview Guides that question their PREA training and overall knowledge of the agency's zero tolerance policy, reporting mechanisms available to residents and staff, the response protocols when a resident alleges abuse, and first responder duties. The Auditor also interviewed specialty staff to include medical and mental health staff, intake staff, master control staff, and human resources and training staff. In addition, the auditor interviewed volunteers, contractors, SAFE/SANE staff, victim advocates, intermediate or higher-level facility staff, the facility administrator/agency head, and PREA Coordinator. The facility does not have a PREA compliance manager. The facility's leadership accommodated the auditor's request to interview specific staff and covered resident supervision while staff were participating in the interview process.

While at the facility, the auditor reviewed ten resident case records, two from each housing unit which were randomly selected by the auditor utilizing a roster of detainees provided to the auditor by the facility, to evaluate screening and intake procedures, resident education, and other general programmatic areas. The auditor also reviewed twelve employee files and 100% of employee training records to determine compliance with training mandates and background check procedures. All documents reviewed by the auditor were within a one-year period from date of audit.

To obtain information about the rape crisis center and advocacy services, an interview was conducted with a representative from the Southern Arizona Children's Advocacy Center. Interviews were also held with a representative from the school and health services department.

On the final day of the onsite audit, a debriefing was held with the facility's leadership staff. The purpose of the meeting was to summarize preliminary audit findings. During this process, specific feedback was provided and included program strengths and areas of improvement as it relates to PREA standards.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Pima County Juvenile Court Center has a designed capacity of 55 beds, located in Tucson Arizona. All are single occupancy sleeping rooms. The facility consists of one single building with five housing units. Two of the five units are co-ed units, and the other three units are for male residents only. A toilet and sink is located within in each sleeping room (cell) where residents can access privately and out of view. Residents are able to change clothes in private within their assigned cell. The Pima County Juvenile Court Center houses both county and U.S. Marshal Residents ages 11 through 17. At time of audit, there were no U.S. Marshal residents detained. No residents older than 18 years of age are detained. The facility security level is considered as a secure facility. Residents are secured with mechanical restraints when leaving the facility.

The building contains an administration area which is accessible through the master control located in main entrance. The main entrance is controlled by the master control. Master control is staffed 24 hours per day, seven days per week. The facility is controlled by locking doors that is controlled by master control. The school and medical units are located within the single building. The school has five classrooms and a library area. The medical unit contains one medical exam room that is utilized for residents, a pharmacy, and office space. There is a minimum of one nurse assigned to the detention facility at any given time. Small recreation yards, with concrete floors, are adjacent to each of the five housing units. Each housing unit contains a common day room that is used for eating meals, and programming, as well as a separate meeting room.

The facility is fairly large in size and has a separate area for intake and processing. This area has a bathroom that is used for strip searches and showering. The Superior Courthouse where residents are seen by the Judge is located within the facility. The facility implements direct podular supervision, where staff can visually supervise residents. In addition, residents are able to move from one area to another, unescorted, and movement is monitored through master control. Programming is conducted daily by staff in the housing units. Residents have access to onsite medical and mental health services. Visitation is available daily for parents and guardians and other preapproved family members over the age of 18. Attorney visits can occur daily.

The average length of stay for a resident in The Pima County Juvenile Court Center is 24 days. At time of audit, 45 residents, 36 males and 9 females, were detained. The facility currently has 124 staff employed at the facility, full-time and part-time, and two authorized contractors. Due to the Juvenile Detention Alternative Initiate (JDAI) through the Annie Casey Foundation, residents detained at any given time have been relatively low.

The facility is equipped with a video monitoring system internally and externally which is monitored by a staff member assigned to the Master Control room. Master Control personnel also control the movement of staff and residents throughout the facility. Meals are prepared onsite in an approved kitchen and are transported by kitchen staff to each housing unit.

SUMMARY OF AUDIT FINDINGS

In the past 12 months, The Pima County Juvenile Court Center reported that eleven allegations of sexual abuse or sexual harassment were received. All eleven allegations were harassment related and all were unfounded. There were no administrative investigations and no criminal investigations related to sexual abuse conducted at The Pima County Juvenile Court Center.

Overall, the interviews with residents reflected that they were aware of and understand the PREA protections and the agency's zero tolerance policy. It was unclear if all residents receive written materials at intake that provide detailed information about PREA protections, the multiple ways to report sexual abuse or harassment and ways to protect themselves from abuse. All new residents are provided with an orientation by the PREA Coordinator within seven days of intake. Residents were able to articulate to the auditor what they would do and who they would tell if they were sexually abused. Residents consistently indicated to the auditor that they felt safe in the facility.

All facility staff interviewed indicated that they had received detailed PREA training and could articulate the meaning of the agency's zero tolerance policy. There is confusion among staff as to their responsibilities as a first responder for any PREA related allegations; as well as how and who conducts investigations internally.

The auditor was able to confirm that an agreement was in place with Southern Arizona Children's Advocacy Center to provide rape crisis intervention services and SAFE's/SANE's forensic services for victims of sexual abuse. An agreement is also in place with the Tucson Police Department to conduct sexual abuse investigations.

In summary, after reviewing all pertinent information and after conducting resident and staff interviews, the auditor found that the agency should devote time to staff training, policy development, risk screening tools, and third party reporting mechanisms. In discussion with facility leadership, they are very eager to begin working on the corrective action items to become in full compliance with PREA standards.

Number of standards exceeded: 2

Number of standards met: 15

Number of standards not met: 21

Number of standards not applicable: 3

FINAL AUDIT UPDATE

The Interim Compliance Report reflected there were 21 standards that were in non-compliance at the Pima County Juvenile Court Center. The facility was given a required correction action period not to exceed 180 days that began on November 16, 2016. The auditor recommended a corrective action plan for the facility and facility staff began immediate corrections of those standards found to be in non-compliance. The auditor reviewed all submitted documentation to determine if full compliance with the standards were achieved. The auditor was able to ask clarifying questions of the PREA Coordinator regarding the verification documents and requested additional documentation. The auditor provided the facility notification as standards were met. Pima County Juvenile Court Center completed the required corrective actions requested by the auditor to bring the facility into full compliance with the PREA standards as of the date of this final report.

Number of standards exceeded: 3

Number of standards met: 35

Number of standards not met: 0

Number of standards not applicable: 3

Total Standards: 41

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Facility policy *A-307 PREA* was developed in 2007 and updated in 2016. This policy mandates zero tolerance toward all forms of sexual abuse and sexual harassment in the Pima County Juvenile Court Center (PCJCC) facility which it directly operates. The policy outlines how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. It also includes a list of prohibited behaviors regarding sexual abuse and sexual harassment. The policy includes sanctions for those found to have participated in prohibited behaviors. Additionally, the policy includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents.

The agency employs an upper level, agency wide PREA Coordinator. The position of the PREA Coordinator is not specified in the organizational chart submitted by the facility. The facility submitted a job description for the Detention Program Coordinator. The auditor was able to verify that the Detention Program Coordinator serves as the PREA Coordinator, and is responsible for the implementation of efforts to comply with the PREA standards. The PREA Coordinator reports directly to the facility's Division Director. The job description is located on the Pima County Superior Court's website.

During interview, the PREA Coordinator confirmed that she has sufficient time and authority to oversee agency efforts to comply with the PREA standards. The facility does not operate more than one facility, therefore does not have a designated PREA Compliance Manager.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

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)

☒ Not Applicable

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

According to the Agency Contract Administrator, the facility has not entered into or renewed a contract for the confinement of residents on or after August 20, 2012, or since the last PREA audit, whichever is later. There are no contracts to review for this standard.

This standard is not applicable.

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.

According to facility policy A-051 Direct Supervision (updated 2016) the agency is obligated to maintain staffing ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours.

The agency submitted "Pima County Juvenile Detention Facility Staffing Plan" that contains information on the facility design, resident population, staffing positions and daily assignments, staff to youth ratios, staff supervision of residents, staff training and equipment, resident education and programs, and staffing plan review. The staffing plan indicates that there are two cameras placed in each living unit dayroom and one in each sally port. Detention main corridors also have cameras. The staffing plan review section states the plan will be reviewed whenever necessary, but no less frequency than once per year. The review process will assess and determine whether adjustments are needed to this plan for compliance with PREA standards 115.313 (a) 1-11. The facility staffing plan indicates that the facility maintains staff ratios. No documentation of deviations was submitted by the facility as it reports that in the past 12 months, the number of times the facility deviated from the staffing ratios of 1:8 security staff during resident waking hours is zero; and during 1:16 security staff during resident sleeping hours is zero. The staffing plan specifies that the PREA Coordinator and Detention Director will review the staffing plan, staffing patterns, the deployment of monitoring technology, and the allocation of resources needed to commit to the staffing plan to ensure compliance with the staffing plan.

The facility submitted a "Staffing Plan Assessment" form that is used to review staffing patterns, policies, procedures, facility monitoring systems, and other monitoring technologies in use. According to the PREA Coordinator, this is a newly developed form (created August 2016). The first annual review will be in August 2017, and every August thereafter. Due to this process being new, there were no additional annual assessments to review.

The welfare/cell check form that was submitted for lead staff to document unannounced rounds is insufficient as it reflects lead staff monitoring 15-minute cell checks once per month, but not welfare checks of every resident on a regular basis. No other documentation was available for review.

During interview, the Superintendent stated that the agency formalized the staffing plan this year (2016) and will be reviewing it annually. The Superintendent stated that when assessing adequate staffing levels and the need for video monitoring, the facility staffing plan will consider: local and state standards, PREA standards, school activity, and staffing patterns. In addition, shift reports will be used to check for compliance with the staffing plan. The Superintendent stated that supervisors send an email out to management to document when the facility is unable to meet the requirements of the staffing plan. The Superintendent stated that the agency utilizes intermittent, on-call juvenile detention officers in order to meet the staffing plan and remain in compliance with ratio. An on-call list is maintained and managed by detention administration. The Superintendent also stated that the agency is obligated by Arizona Office of the Courts (AOC) to maintain staffing ratios. This was verified by reviewing the AOC detention standards.

According to the PREA Coordinator, the facility does not have a policy addressing how to conduct PREA unannounced rounds and that lead staff conduct unannounced rounds of residents. The PREA Coordinator reports that since August 20, 2012, or the last PREA audit, whichever is later, the average daily number of residents is 24 and the average daily number of residents on which the staffing plan was predicated is 24.

The current facility population is 45 which is inconsistent with the average daily attendance of 24 that was reported by the PREA Coordinator. As the staffing plan is in its early implementation phase, it is recommended that the facility re-assess the staffing plan a minimum of every 12 months and re-evaluate as needed.

Interviews with three lead staff detected that unannounced rounds are not documented. As well, lead staff does not understand the reasoning behind conducting such rounds. The PREA Coordinator stated that lead staff conduct unannounced rounds, however during interview with the three lead staff, there tends to be confusion between verifying that 15-minute cell checks are completed and conducting PREA unannounced rounds. Lead staff also stated that they only complete such rounds once per month and that they do not account for each resident when doing so.

Based on the evidence discussed, the facility has not demonstrated compliance with this standard due to the need for staff training and a written procedure for conducting unannounced rounds, and this auditor has recommended the following corrective action items to be completed within six months.

CORRECTIVE ACTION NEEDED:

1. The facility will provide staff training on how to conduct announced rounds, the purpose of unannounced rounds, and how to document rounds. This will be verified by submitting a training agenda and sign in roster to the auditor.
2. The facility will develop a procedure and form to document the ongoing occurrence of unannounced rounds. The facility will submit to the auditor a written procedure, tracking form, and a 30-day sampling of unannounced rounds being conducted on each shift daily.

VERIFICATION OF CORRECTION ACTION:
The Auditor was provided appropriate supplemental documentation on December 20, 2016 to evidence and demonstrate corrective actions taken regarding this standard.

Additional Documentation Reviewed:

- A sign in roster was submitted to the auditor as verification that seven supervisors received training on "Unannounced Rounds". The roster was dated October 6, 2016 and November 10, 2016.
- Agenda items were submitted to include protocol of conducting and documenting unannounced rounds. Protocol states that rounds will be conducted one time per shift to ensure constant compliance. The protocol states that staff will ensure that all residents are accounted for and that unannounced rounds are documented.
- A sampling of "PREA Unannounced Rounds Log" were submitted to the auditor for review. The logs were dated between November 11, 2016 and December 16, 2016. The logs documented the shift, time, any issues or comments and staff signature of all unannounced rounds conducted. Distribution of completed logs are notated on the form and are to be turned in to the PREA Coordinator when sheet is completed.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

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.

Facility policy *C-201 Youth and Facility Searches* state all searches, excluding the unit, room, and wand searches, shall be conducted by personnel of the same sex as the youth being searched. This policy requires that all cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat down searches be documented on a strip search authorization form and verified by a juvenile detention supervisor or designee. No documentation of cross-gender searches is available.

Facility policy *A-051 Direct Supervision* that enables residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia.

Facility policy *A-307 PREA* prohibits staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the residents genital status. Staff stated that they are aware of the facility's policy that prohibits staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the residents genital status. At time of audit, the facility did not have any transgender residents to interview.

There are no logs of cross gender pat down searches to review.

During the tour of the facility, the auditor observed that there were three resident showers in each housing unit. All showers are single use only. Resident showers have doors concealing residents from observers. Only a residents head and feet can be observed. There are two cells located directly across from the showers in the two co-ed (male/female) units. The cell doors have windows and the cells were occupied by residents. Staff report that residents are to remain seated on their beds when other residents are showering to avoid having a visual of those in the shower.

During random staff interviews, all staff stated that they are restricted from conducting cross-gender strip or visual body cavity searches and that it must be an exigent circumstance and approved by the Detention Director, and only as a last resort that would warrant such a search. During interview with random staff, all staff stated that residents are oriented about the bell system.

All fifteen residents interviewed, reported that staff of the opposite gender of them has not performed a pat down search of their body. During interviews with fifteen residents, one stated that he did not know what the bell was for. Fourteen residents were able to explain to the auditor the purpose and intent of the bell system.

According to the PREA Coordinator, the facility does not have a policy that addresses requiring staff of the opposite gender to announce their presence when entering a resident housing unit or area where residents are likely to be showering, performing bodily functions, or changing clothes. The facility has implemented a bell system that alerts residents of incoming and outgoing staff; however this is not reflected in policy.

In addition, the PREA Coordinator stated that zero percent of staff have been trained in this area. Staff reported that they are prohibited from conducting cross-gender searches. Also, in the last 12 months there have been zero cross-gender strip or cross gender visual body cavity searches that did not involve exigent circumstances or were performed by non-medical staff. The PREA Coordinator stated that the facility does not permit cross-gender pat down searches of residents absent exigent circumstances and that there have been zero cross-gender pat down searches of residents and zero cross-gender pat down searches of residents that did not involve exigent circumstances

During the tour of the facility, and documentation review, this auditor did not see a policy addressing the responsibility of staff of the opposite gender to announce their presence when entering an area where residents are dressing, showering, etc. This is required by this standard, and based on this evidence, the facility is not in compliance with standard 115.315, and this auditor has recommended the following corrective action item to be completed within six months.

CORRECTIVE ACTION NEEDED:

1. A policy must address requiring staff of the opposite gender to announce their presence, and a procedure containing information about the bell system that is in each housing unit should be developed. The facility will submit the policy and procedure to the auditor.

VERIFICATION OF CORRECTION ACTION:
The Auditor was provided appropriate supplemental documentation on January 3, 2017 to evidence and demonstrate corrective actions taken regarding this standard.

Additional Documentation Reviewed:

- The facility submitted revised PREA Policy A-307. The policy now includes the requirement that staff of the opposite gender must announce their presence by using the chime door system. The door automatically sounds a chime when opened to alert residents that someone is entering the living unit and also alerting residents to an active change in people within the unit.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

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.

Facility policy *A-307 PREA* prohibits the use of resident interpreters. The policy outlines procedures to provide 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.

The facility has a Language Access Plan (LAP) revised in 2015 to address the limited English population, primarily Spanish. The plan details services provided to include court interpreters, recruiting and hiring bilingual staff, telephone interpreters that are available 24/7, I Speak cards, video remote interpretation services, translation memory software, and Spanish-English signage, informational brochures, and handbooks.

The LAP states that staff are mandated to attend a LAP training. Employee training logs were reviewed and the auditor was able to verify that all staff have received LAP training. Intake staff report that they utilize the county/court interpreters as needed. According to the Agency Head, the agency has established procedures which are outlined in the LAP to provide residents with disabilities and residents who are limited English proficient 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.

During the tour of the facility, the auditor observed bilingual materials, such as PREA posters and PREA handbooks, available to residents in the housing units and school.

During random staff interviews, staff reported that residents are not allowed to translate for other residents. Staff reported that in the past 12 months there have been zero instances where resident interpreters, readers, or other types of resident assistants have been used and there were no cases that an extended delay in obtaining another interpreter compromised the resident's safety, the performance of first response duties under 115.364, or the investigation of the resident's allegations.

At time of audit there were no residents with disabilities detained, therefore no interviews could be conducted.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

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.

Pima County Superior Court policy *Rule 6 Standards for Filling Vacancies* states that employees undergo a background investigation, to include requirements under PREA; however it does not specify what those requirements are.

During interview with the Deputy Director of Court Human Resources, the facility considers prior incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of a contractor, that may have contact with residents. The policy states that material omissions regarding misconduct or the provision of materially false information shall be grounds for termination. The policy also addresses that unless prohibited by law, the facility 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.

Pima County Superior Court policy *201 Background Investigation*, requires before it hires any new employees who may have contact with residents, to (1) conduct a criminal background record check; (2) consult with a child abuse registry; and (3) make best efforts to contact all prior institutional employers to information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. The policy requires that criminal background checks be conducted at least every five years of current employees and contractors who may have contact with residents.

Pima County Superior Court policy *201 Background Investigation* describes the process for asking applicants and employees who may have contact with residents directly about previous misconduct in written applications or interviews for hiring or promotions or in any interviews or written self-evaluations conducted as part of reviews of current employees.
Interview with the Human Resources staff indicate that this is done by questionnaire that is notarized. Staff are mandated by policy to report instances of misconduct immediately.

The facility does not have a policy that 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:

1. Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution;
2. 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
3. Has been civilly or administratively adjudicated to have engaged in the activity described in #2 above.

The auditor reviewed a sample of personnel files from the past 12 months and found that the facility prohibits hiring and 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; or 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 #2 above. According to the Court Human Resources staff interviewed, this has been a practice but is not written in policy.

According to the Court Human Resources Staff, the Court Human Resources department completes the criminal background checks annually. Documentation of personnel files support that this is completed annually for employees and contractors. The facility does not have a policy that addresses background checks of contractors.

The Court Human Resources staff stated that the facility performs criminal record checks for all newly hired employees who may have contact with residents and all employees who are being considered for promotions. In August 2015, the facility began consulting with the Arizona Department of Child Services Child Abuse Registry before hiring new employees or contractors who may have contact with residents.

Through the review of personnel files, the auditor verified that the child abuse registry check is being conducted. Background checks and child abuse registry checks were also reviewed for all three contractors. According to the Court Human Resource staff, files are maintained by the Court Human Resources Department. The Court Human Resources staff said that upon a signed release of information, the facility will provide information on substantiated allegations of sexual abuse or sexual harassment involving the former employee.

The PREA Coordinator reports that during the past 12 months, 37 persons hired who may have contact with residents received criminal background checks and that three contracts are in place for services where criminal background record checks were conducted on all staff covered in the contract that might have contact with residents.

Based on the evidence discussed, the facility has not demonstrated compliance with this standard due to the amount of missing information from policies regarding background checks and the hiring and promoting of employees to include contractors, and this auditor has recommended the following corrective action items to be completed within six months.

CORRECTIVE ACTION NEEDED:

1. A facility policy must include conducting background checks and child abuse registry checks on all contractors who may have contact with residents. Facility will submit a policy regarding contractor background checks to meet this standard to the auditor.
2. The facility must develop a policy that prohibits hiring and promoting employees, to include contractors, who have engaged, were convicted, or adjudicated in sexual abuse. Facility will submit a policy regarding contractor background checks to meet this standard to the auditor.

VERIFICATION OF CORRECTION ACTION:
The Auditor was provided appropriate supplemental documentation on January 3, 2017 to evidence and demonstrate corrective actions taken regarding this standard.

Additional Documentation Reviewed:

- The facility submitted revised PREA Policy A-307. The policy now includes conducting background checks and child abuse registry checks on all contractors who may have contact with residents and the policy states that those who have engaged in, were convicted of or adjudicated in sexual abuse will not be hired or promoted.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

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.

During the facility tour, the auditor observed the video surveillance system in Master Control. Tour of facility indicated that there are major areas within the facility that residents have access to that are not under video surveillance. Those areas are identified as the MAC Family Counseling Room, Intake unit, property storage room, and the school/classroom in the older section of facility. Also in the property storage room, which is adjacent to the intake showering rooms, high shelving units impede the line of sight and create critical blind spots. According to interviews with intake staff, residents with a staff member, enter the property storage room after showering to place their belongings in a storage tote. The auditor conducted a visual inspection of the property storage room and found it to have limited visibility and many blind spots due to the high shelving in the room. According to the Detention Director and Agency Head, there is a prioritized plan in place for upgrades to the video monitoring system.

According to the Agency Head, the facility has not acquired a new facility or made a substantial expansion or modification to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later. The Agency Head stated that there are not any areas of new renovations. According to the Agency Head, the facility uses new monitoring technology to enhance the protection of residents from incidents of sexual abuse by avoiding blind spots and using the playback feature on video surveillance.

The PREA Coordinator reported that they have 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.

Based on the evidence discussed, the facility has not demonstrated compliance with this standard due to the amount of blind spots in critical areas of the facility, and this auditor has recommended the following corrective action items to be completed within six months.

CORRECTIVE ACTION NEEDED:

1. The facility must formulate a plan of action to address limited visibility in resident accessible rooms, to include MAC

Family Counseling Room, Intake unit, property storage room, and school/classroom in older section of facility. This formalized plan must be submitted to the auditor.

2. The property storage room, which is adjacent to the showering rooms, have high shelving unit's that impede the line of sight and create critical blind spots. The facility shall develop a plan to eliminate secluded areas and provide a better visual of the entire room. This plan shall be submitted to the auditor.

VERIFICATION OF CORRECTION ACTION:
The Auditor was provided appropriate supplemental documentation on February 22, 2017 to evidence and demonstrate corrective actions taken regarding this standard.

Additional Documentation Reviewed:

- The Limited Visibility Plan has been developed and addresses blind spots in the MAC Family Counseling Room, Intake, Processing Rooms, and the 1100 Classroom.
- Photos of posted signs were submitted to the auditor. Signs are posted at the inner classroom door/entrance stating Juvenile Detention Officers only beyond this point when school is not in session. Signs on the Girls Processing door, the Boys Processing door and the Living Unit Supply Closet door states "This Door To Remain Closed. JDOs Only Beyond This Point". There is a sign in the MAC Counseling Room stating that the blinds must remain open.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

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.

Policy *Sexual Misconduct and Undue Familiarity* states that forensic medical exams are free and that the facility attempts to make a victim advocate from a rape crisis center available to the victim, in person, or by other means.

A Memorandum of Understanding (MOU) is in place with Southern Arizona Children's Advocacy Center and the Tucson Police Department that documents efforts to provide SAFE/SANE staff and to provide victim advocacy services. The MOU states that the Tucson Police Department Sex Crimes Unit for Juveniles will refer all residents to the Southern Arizona Children's Advocacy Center for forensic medical exams, and advocacy services. The MOU outlines the responsibilities of each party to provide a multidisciplinary team approach to sexual abuse investigations in compliance with PREA. The MOU also states that all resident victims of sexual abuse have access to forensic medical exams and the MOU delineates responsibilities of outside medical and mental health practitioners. According to information contained in the MOU, the agency has requested that the responsible party for conducting administrative or criminal investigations follow requirements contained in 115.321 (a) through (e) and that if requested by the victim, a victim advocate, or qualified agency staff member, or qualified community-based organization staff member accompanies and supports the victim through the forensic medical examination process and investigatory interviews and provides emotional support, crisis intervention, and referrals.

The auditor reviewed training curriculum and documentation of training received that verifies the PREA Coordinator has been sufficiently trained to conduct administrative investigations. The facility follows a uniform evidence protocol for administrative investigations that maximizes the potential for obtaining usable physical evidence. The protocol is based on the DOJ Office on Violence Against Women published protocol. According to the PREA Coordinator, she is designated the internal investigative staff. The response time to initiate an investigation following an allegation of sexual abuse or sexual harassment is immediate. Once an allegation is made, staff reports it to the PREA Coordinator. In turn, the PREA Coordinator gathers the facts, reviews video, if applicable, and notifies the Tucson Police Department. According to the PREA Coordinator,

anonymous and third party reports are not handled differently and that third party reports are also investigated thoroughly and objectively. The PREA Coordinator only conducts non-criminal internal investigations. All other investigations are referred to the Tucson Police Department for investigation.

The auditor was able to review the "Pima County Protocol for the Violence Against Women Act – Right to a Medical Forensic Examination". This protocol is available on the Pima County website and outlines how the Tucson Police Department and the Southern Arizona Children's Advocacy Center will provide medical forensic exams to victims of sexual assault, age 13 and older, who present within 120 hours post-assault, regardless of whether they choose to report the assault to law enforcement.

The PREA Coordinator reports that she is responsible for conducting administrative non-criminal sexual abuse investigations (including resident on resident sexual abuse and staff sexual misconduct). Tucson Police Department and Southern Arizona Children's Advocacy Center has the responsibility of conducting criminal sexual abuse investigations. The PREA Coordinator also stated that they offer to all residents who experience sexual abuse access to forensic medical examinations and that forensic medical examinations are offered without cost to the victim. Where possible, examinations are conducted by Sexual Assault Forensic Examiners (SAFE's) or Sexual Assault Nurse Examiners (SANE's). The PREA Coordinator also stated that during the past 12 months, zero forensic medical exams have been conducted.

All random detention officers that were interviewed reported they are responsible for conducting administrative investigations prior to turning it over to a lead staff or supervisor. Additionally, all staff interviewed reported that they have not received training in this area. The PREA Coordinator stated that all staff has a part in the investigative process. According to staff interviewed, an investigation is completed on each level of the organizational chart, prior to notifying the PREA Coordinator or Detention Director. Additionally, staff are not consistent as to what their role would be. The confusion may be in part to a new PREA policy that was recently issued just days before this audit visit. Staff are unfamiliar with it and do not understand the protocol to follow.

During interview with the Director of the Southern Arizona Children's Advocacy Center, it was stated that the protocol is developmentally appropriate for youth and adapted from or otherwise based on the most recent edition of the DOJ's Office on Violence Against Women's publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011. According to the SAFE/SANE staff, they are responsible for conducting all forensic medical examinations for the facility. SAFE/SANE staff is available 24 hours a day, every day, utilizing on-call staff. SANE staff are pediatric certified. The Southern Arizona Children's Advocacy Center also provides forensic interviews.

The Agency Head stated that if and when a rape crisis center is not available to provide victim advocate services, the facility provides a qualified staff member from a community-based organization or a qualified agency staff member.

At time of audit, there were no residents who reported sexual abuse to interview.

Based on the evidence discussed, the facility has not demonstrated compliance with this standard due to the confusion that detention officers believe that they are responsible for conducting administrative sexual abuse investigations, and this auditor has recommended the following corrective action item to be completed within six months.

CORRECTIVE ACTION NEEDED:

1. The facility must provide training to staff regarding the investigative process, what their roles are, when and to whom to report too. The facility will submit the training agenda, handouts, and staff sign in roster to the auditor as verification of completion.

VERIFICATION OF CORRECTION ACTION:
The Auditor was provided appropriate supplemental documentation on February 17, 2017 to evidence and demonstrate corrective actions taken regarding this standard.

Additional Documentation Reviewed:

- The facility submitted a training agenda entitled "PREA Investigative Training" that was conducted on February 16, 2017. The main focus of the training was to inform all juvenile detention officers that PREA investigations are conducted by designated staff that have completed specialized Sexual Assault Investigator Training.
- Copy of training handout was submitted to the auditor. The handout describes the specialized training for investigators and first responder responsibilities.
- Copy of the sign in roster verifies that all juvenile detention officers received this training.
- Understanding of Training form was signed and dated by each officer to acknowledge training received.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy *A-307 PREA* requires allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, including the agency if it conducts its own investigations, unless the allegation does not involve potentially criminal behavior. This policy describes the process of referrals of allegations of sexual abuse or sexual harassment for a criminal investigation and it is published on the agency's website. The policy states that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.

The facility has a MOU with the Tucson Police Department that describes investigative responsibilities of both the agencies.

The PREA Coordinator reported that they document all referrals of allegations of sexual abuse or sexual harassment for criminal investigation. The auditor was able to review samples of documentation of reports, including investigative findings. The PREA Coordinator also reported that in the past 12 months they received 11 allegations of sexual harassment. Zero of which resulted in an administrative or criminal investigation. According to the PREA Coordinator, she conducts internal investigations by collecting the facts and reviewing video. Tucson Police Department conducts all criminal investigations. A thorough explanation of the referral process can be found in standards 115.321 and 115.371.

According to the Agency Head, the agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse or harassment. The Detention Director is designated to ensure that all investigations are completed and stated that an MOU with the facility, advocacy center, and police department will be followed.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

Standard 115.331 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy *A-307 PREA* outlines staff training requirements, to include PREA training.

In review of the PREA training curriculum, the agency trains all employees who may have contact with residents on all areas identified in 115.331 (a) (1) through (11). The curriculum describes how the agency tailors training to the unique needs and

attributes and gender of the residents at the facility and that employees who are reassigned from facilities housing opposite gender are given additional training.

In review of employee training records, staff received two hours of PREA training in March 2016 and Pre and Post tests were given to staff and maintained in their training files. Staff PREA acknowledgement forms indicating their understanding of and compliance with the PREA standards and facility policies regarding sexual abuse and sexual harassment are signed by every staff at time of training and located in the training.

According to random staff interviewed, a formalized PREA training is provided annually, which lasts a minimum of one hour.

The PREA Coordinator reported that there is 112 staff currently employed by the facility, who may have contact with residents, who were trained or retrained on the PREA requirements. This number reflects full-time and on-call staff. The PRE Coordinator also reported that between training, the agency provides employees who may have contact with residents refresher information about current policies regarding sexual abuse and harassment and that employees who may have contact with residents receive refresher training annually on PREA requirements. It was also stated that the facility documents that employees who may have contact with residents understand the training they have received through employee signature or electronic verification.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

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.

In review of the training curriculum, the level and type of training provided to volunteers and contractors is based on the services they provide and level of contact they have with residents.

Training records of contractors and volunteers were reviewed to assure compliance with training requirements.

The agency maintains signed acknowledgement forms confirming that volunteers and contractors understand the training they have received. These are maintained in the PREA Coordinator's office.

The PREA Coordinator reported that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response and that there are 17 volunteers and contractors, who have contact with residents, which have been trained. According to the PREA Coordinator, the facility utilizes the same training curriculum as the staff training.

According to the volunteers and contractors interviewed, they have been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents to include identifying red flags through a PREA orientation training that included a PowerPoint, video, and handouts. They were also asked to sign an acknowledgement form to verify their understanding and compliance with PREA. They stated that they are invited to attend staff PREA training that is held annually. The volunteers and contractors interviewed have a very good understanding of PREA and their role in reporting.

Based on the evidence discussed, the facility has exceeded compliance with this standard by providing multiple training opportunities to volunteers and contractors.

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.

A-307 PREA policy governs PREA education and states that resident education materials are available in English and Spanish and new residents receive a PREA orientation that is provided within the first week of detainment.

Residents receive a PREA Youth Handbook at intake, which is available in English and Spanish. The handbook covers PREA basics, how to report, how to stay safe, and what to do if abuse happens. The material contained in the handbook is presented in age appropriate fashion.

During the tour of the facility, the housing units did not have sufficient comprehensive education materials about staying safe and ways to report and there was not any educational literature available for residents to review. Only two of the housing units contained a poster in English and Spanish that contain hotline numbers and ways to report. This information was sporadic and inconsistent between units. The information was not displayed in school, medical, or visitation. The posters were not prominently displayed. In fact, the PREA Coordinator had to search for the postings. One poster was located on the floor after falling from the wall. The housing units did not have sufficient comprehensive education materials about staying safe and ways to report. There was not any educational literature available for residents to review.

The facility was unable to produce documentation to the auditor to verify that the PREA handbook was reviewed with the residents during intake. The auditor was able to verify new resident participation in the weekly PREA education sessions through signed rosters.

The PREA Coordinator reported that residents received information at time of intake about the zero tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. Of residents admitted during the past 12 months 595 residents received this information at intake. The PREA Coordinator reported that of the residents admitted during the past 12 months, 466 residents received comprehensive education within 10 days of intake. The PREA Coordinator stated that resident PREA education is available in accessible formats for all residents including those who are limited English proficient, deaf, visually impaired, otherwise disabled, and have limited reading skills. The PREA Coordinator stated that it is her responsibility to ensure that the key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats. The PREA Coordinator was unable to explain to the auditor details about how accessible formats are delivered to the residents or how they are made readily available.

Intake staff stated that a booklet is given to residents to review and it is available in English and Spanish during intake and that residents are oriented daily in the units about PREA. Intake staff reported that comprehensive education begins at time of intake with a review of the PREA handbook. Weekly, new residents attend an orientation provided by the PREA Coordinator. PREA is also discussed daily in the units. Intake staff stated during interview that residents do not sign an acknowledgement form of their understanding of PREA.

Fourteen of the fifteen residents interviewed confirmed that they received PREA education at time of intake in the form of a handbook, however, all fourteen residents stated that the handbook was given to them, not reviewed, and they were encouraged to read it in their spare time.

Based on the evidence discussed, the facility has not demonstrated compliance with this standard due to the inconsistency of the resident PREA handbook being reviewed and the lack of resident education throughout the facility, and this auditor has recommended the following corrective action items to be completed within six months.

CORRECTIVE ACTION NEEDED:

1. The resident PREA handbook at time of intake must be consistently reviewed with residents and their understanding of PREA shall be documented. A 30-day sample of resident acknowledgements must be submitted to the auditor.
2. PREA informational posters, booklets, and/or pamphlets in English and Spanish shall be made available in each unit, classroom, medical, library, visitation, and other resident accessible areas. The facility shall submit copies of posters, booklets, and other PREA-related educational materials to the auditor. In addition, photos of material placement shall be submitted to the auditor to verify placement.

VERIFICATION OF CORRECTION ACTION:
The Auditor was provided appropriate supplemental documentation on December 19, 2016 to evidence and demonstrate corrective actions taken regarding this standard.

Additional Documentation Reviewed:

- Twenty-two Zero Tolerance Youth Acknowledgement forms were submitted between the period of November 6, 2016 and December 15, 2016 to fulfill the 30-day sampling. The form outlines expectations, how to report, and definitions of sexual abuse and harassment. The form also includes acknowledgement that the resident was provided a PREA booklet and that the resident understands the information provided to them. The form is designed to be reviewed by a staff member with the resident and is signed by both staff and resident.
- Third party PREA Brochures in English and in Spanish was submitted to the auditor. The Brochures contains information and instructions on how to report an alleged sexual assault or sexual harassment as a third party on behalf of a resident.
- Photos of PREA informational posters were submitted to the auditor. Photos verified that the posters are visible in living units 100, 200, 300, 400 and 500; classrooms 600, 1100, 1200, 1400, and 1500; master control lobby/visitation area; and in the medical unit. Posters are in English and Spanish and contain information on ways a resident can report sexual abuse and sexual harassment including six important/hotline phone numbers that residents can contact.
- Photos were submitted to verify placement of PREA booklets in the master control/visitation lobby. Booklets are now available in English and Spanish.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

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)

☒ Standard Not Applicable

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

According to the Agency Head, the agency does not conduct criminal sexual abuse investigations. In an agreement with the Tucson Police Department, they have trained investigators that conduct sexual abuse investigations for the facility.

This standard is not applicable.

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.

Agency policy *A-307 PREA* refers to the training of medical and mental health practitioners who work regularly in its facilities.

The auditor verified documentation (signed rosters) showing that medical and mental health practitioners have been trained in zero tolerance and first responder duties. Medical staff is not trained to conduct forensic examinations.

The PREA Coordinator reported that 100% (25) of all medical and mental health care practitioners who work regularly at this facility received the training required by agency policy. Medical and mental health staff stated during interview that they received training. The auditor was able to review the training video content and signed rosters and validate training received.

Facility medical staff reported that medical staff at this facility does not conduct forensic medical exams and that a Memorandum of Understanding has been developed with Southern Arizona Children's Advocacy Center to provide forensic medical exams by SAFE/SANE examiners.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy A-307 PREA contains the procedures related to screening residents. According to the PREA Coordinator and staff responsible for risk screening, assessments are placed in a secure file. All detention officers have access to the file, including supervisors, and probation officers. The policy also requires that a resident's risk level be reassessed periodically throughout their confinement.

The auditor reviewed a sample of resident records and verified that residents were screened within 72 hours of intake.

The agency utilizes the *Detention Classification and Detainment Form 52A* which is an objective screening instrument to screen residents upon admission to the facility for risk of sexual abuse victimization or sexual abusiveness toward other residents.

The screening instrument, Detention Classification and Detainment Form 52A, ascertains the following information:

- Any gender nonconforming appearance or manner
- Current charges and offense history
- Age
- Physical size and stature
- Level of emotional or cognitive development
- Mental illness and mental disabilities
- Residents own perception of vulnerability
- Specific information that may indicate a heightened need for supervision, safety precautions, or separation.

The screening instrument, Detention Classification and Detainment Form 52A, does not ascertain the following information:

- Prior sexual victimization or abusiveness
- Intellectual or developmental disabilities
- Physical disabilities

The PREA Coordinator reports that 595 residents entering the facility within the past 12 months whose length of stay in the facility was for 72 hours or more were screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their entry into the facility.

Based on the evidence discussed, the facility has not demonstrated compliance with this standard due to the screening instrument not ascertaining all information needed, and this auditor has recommended the following corrective action item to be completed within six months.

CORRECTIVE ACTION NEEDED:

1. Detention Classification and Detainment Form must ascertain the following information:
   a. Prior sexual victimization or abusiveness
   b. Intellectual or developmental disabilities
   c. Physical disabilities

   A 30-day sample of completed Detention Classification and Detainment Forms shall be submitted to the auditor for verification.

VERIFICATION OF CORRECTION ACTION:
The Auditor was provided appropriate supplemental documentation on December 5, 2016 to evidence and demonstrate corrective actions taken regarding this standard.

Additional Documentation Reviewed:

- Initial Detention Assessment (IDA), Integrated Intake Screen (C-765), Health Assessment Screen (C-757), Mental Health Initial Evaluation and Treatment Screen (C-815A) were submitted by the facility. The forms collect information regarding residents pertaining to prior sexual victimization or abusiveness, intellectual and developmental disabilities, and physical disabilities. The Screens are completed during intake by medical staff. Targeted behaviors, strategies, diagnostic impressions, and a treatment plan is developed, if needed, based on the findings of the information received.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy *A-307 PREA* states that residents at risk of sexual victimization may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged. The policy requires that residents at risk of sexual victimization who are placed in isolation have access to legally required educational programming, special education services, and daily large-muscle exercise. The

policy also discusses reassessment for transgender and intersex residents and that the facility makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis.

The facility was unable to provide documentation of reassessment for transgender and intersex residents, or housing assignments of LGBTI residents as the facility has not yet detained a LGBTO resident. There is also no documentation available for how decisions risk based housing decisions are made.

It was observed during the tour of the facility that there were no residents being held in isolation. During the tour, the auditor was able to observe single shower use. Showers have hard doors and residents head and feet are visible for safety precautions.

According to staff responsible for risk screening, residents are assigned to housing units by age and behavior only. The risk screening tool does not ascertain information related to informing housing, bed, work, education, and program assignments with the goal of keeping all residents safe and free from sexual abuse. According to staff, reassessment is determined by a supervisor and that residents are placed wherever they feel comfortable. Staff also stated that residents are able to shower and dress separately. Staff stated that they would report any concerns immediately to the supervisor and mental health clinician and they would also complete a MAYSI screening on the resident.

The PREA Coordinator reports that they prohibit placing lesbian, gay, bisexual, transgender, or intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status. She also reported that they prohibit considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. The PREA Coordinator reported that zero residents have been held in isolation and that in the past 12 months, zero residents have been placed in isolation. The PREA Coordinator reported that the facility uses information from the risk screening required by 115.341 to inform housing, bed, work, education, and program assignments with the goal of keeping all residents safe and free from sexual abuse.

There were no Transgender/intersex residents, no LGBTI residents, and no residents placed in isolation to interview.

Based on the evidence discussed, the facility has not demonstrated compliance with this standard due to the detention classification and detainment form not ascertaining housing, bed, work, education, and programming assignments to keep residents free of sexual abuse, and this auditor has recommended the following corrective action item to be completed within six months.

CORRECTIVE ACTION NEEDED:

1. Detention Classification and Detainment Form shall be revised to ascertain housing, bed, work, education, and programming assignments to keep residents free of sexual abuse. A copy of the revised form shall be submitted to the auditor.

VERIFICATION OF CORRECTION ACTION:
The Auditor was provided appropriate supplemental documentation on February 1, 2017 to evidence and demonstrate corrective actions taken regarding this standard. Additionally, it contains a section specifically dedicated to Classification Assignments.

Additional Documentation Reviewed:

- The facility submitted a revised 52A Classification, Detainment & Property Collection Form. This form now captures housing, bed, work, education, and programming assignments to keep residents free of sexual abuse.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has a policy *A-307 PREA* mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. This policy establishes 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 policy includes procedures for staff to privately report sexual abuse and sexual harassment of residents by reporting directly to the PREA Coordinator and that staff are informed of these procedures through annual staff training.

Policy *G-201 Youth Grievance* contains procedures for residents filing grievances. Residents are allowed to file grievances for PREA allegations by completing a form and submitting to in a grievance drop box.

During the tour, the auditor observed the multiple ways of reporting. Residents can write a grievance and place in the grievance boxes located in the housing units, or place a note in the medical box located in each housing unit. Residents are able to request a phone call to a third party. Additionally, residents can notify a third party during established visitation hours. The agency does have a contract with the Unites States Marshall's (USM) office. The auditor was unable to locate information regarding how USM residents can contact the appropriate consular. Resident handbooks contain information on ways to report sexual abuse and sexual harassment in English and Spanish. The agency 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 agency. Documentation of agreement with outside reporting agency was posted in the housing units. The facility has an internal 800 number that can be called to report alleged incidents of sexual abuse and sexual harassment. This information is located in the resident PREA handbook. Grievance slips and boxes are located in each housing unit. Grievance boxes or tools to report are not located in other resident accessible areas of the facility including medical, school and visitation. The facility provides 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 facility was unable to provide documentation of verbal reports of allegations made by residents. The PREA Coordinator reported that detention staff are required to document verbal reports immediately, however to date, no verbal reports have been made by residents.

Training curriculum was reviewed and contains procedures for staff to privately report sexual abuse and sexual harassment of residents by reporting directly to the PREA Coordinator.

During interviews with random staff, they stated that residents can speak to anyone and they are reminded of this daily during unit orientation. Staff also said that residents can complete a grievance form or a sick call slip. Staff interviewed state that no reports have been received and residents interviewed reported that they have not made a written or verbal report of sexual abuse or sexual harassment. Staff stated that they follow chain of command for reporting such instances unless it is severe, and then they report it directly to the PREA Coordinator or Detention Director. Staff also stated is less severe, such as harassing behaviors, are reported only to the supervisor and then after investigating, the supervisor reports it to the PREA Coordinator if it is severe enough.

Fifteen random residents were interviewed also. All residents stated that they have the option to tell someone in person or by phone and that they can submit a grievance. According to residents, they are able to report sexual abuse and harassment to the Department of Child Services, probation officer, attorney, or their parents. They stated that they can write a note to staff. Residents also stated they cannot privately report in written form as they must place their names on the grievance form or sick call slip. Residents also stated during interview that they can report verbally and in writing immediately.

The Agency Head stated that they do not have a policy requiring residents detained solely for civil immigration purposes be provided information on how to contact relevant consular officials and relevant officials of the Department of Homeland Security due to the facility not housing such residents.

At time of the audit, no USM residents were detained and no residents who reported a sexual assault were available to interview.

Based on the evidence discussed, the facility has not demonstrated compliance with this standard due to the need for staff

training and not having a written procedure for conducting unannounced rounds, as well as needing a procedure for residents to report privately in written form, and this auditor has recommended the following corrective action items to be completed within six months.

CORRECTIVE ACTION NEEDED:

1. The facility shall develop a strategy to allow residents to report sexual abuse or sexual harassment anonymously. The protocol shall be included in the resident PREA handbook, or in a visible location in areas accessible to residents. A copy of the documentation shall be provided to the auditor.
2. The facility shall include in policy requiring residents detained solely for civil immigration purposes be provided information on how to contact relevant consular officials. This information shall also be made available to residents. A copy of the policy and resident information shall be provided to the auditor.
3. The facility must establish a procedure and inform residents that residents are able to report allegations privately and anonymously in written form without having to place their name on the grievance form or sick call slip.

VERIFICATION OF CORRECTION ACTION:
The Auditor was provided appropriate supplemental documentation on January 3, 2017 to evidence and demonstrate corrective actions taken regarding this standard.

Additional Documentation Reviewed:

- The facility submitted revised PREA Policy A-307. The policy now includes a statement that "youth are never detained solely for civil immigration".
- The PREA Slip has been placed in each living unit directly above the grievance box.
- The PREA Youth Acknowledgement Form has been revised to reflect anonymous reporting and the various ways residents can report.
- PREA information is delivered to new residents every Monday and weekly to current residents.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has an administrative procedure Policy *G-201 Youth Grievance* for dealing with resident grievances regarding sexual abuse. The 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. The policy does not require a resident to use an informal grievance process, or otherwise to attempt to resolve with staff, an alleged incident of sexual abuse. The 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 policy requires that a resident grievance alleging sexual abuse not be referred to the staff member who is the subject of the compliant. The policy requires that a decision on the merits of any grievance or portion of a grievance alleging sexual abuse be made within 90 days of the filing of the grievance. The policy limits its ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where the agency demonstrates that the resident filed a grievance in bad faith.

Agency policy, *A-307 PREA*, permits third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist residents in filling requests for administrative remedies relating to allegations of sexual abuse, and to file such requests on behalf of residents. The agency policy requires that if the resident declines to have third party assistance in filing a grievance alleging sexual abuse, the agency documents the resident's decision to decline. The policy

allows for parents or legal guardians of residents to file a grievance alleging sexual abuse, including appeals, on behalf of such resident, regardless of whether or not the resident agrees to have the grievance filed on their behalf.

The resident handbook contains information on how to submit a grievance regarding an allegation of sexual abuse at any time regardless of when the incident is alleged to have occurred and how to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint.

The facility developed a third party reporting pamphlet that is located in the public lobby/entrance area. This pamphlet does not indicate that parents/guardians can request an administrative remedy on behalf of the resident. The pamphlet should be in a place that is more visible to the public and also must be available in other languages than English. The pamphlet should also be located in the visitation area where visitors meet with residents.

The PREA Coordinator reports that in the last 12 months, there have been zero grievances filed alleging sexual abuse, zero grievances alleging sexual abuse filed by residents in which the resident declined third-party assistance containing documentation of the resident's decision to decline, zero emergency grievances filed in the past 12 months, and zero resident grievances alleging sexual abuse that resulted in disciplinary action by the agency against the resident for having filed the grievance in bad faith.

Based on the evidence discussed, the facility has not demonstrated compliance with this standard due to need for additional information to be added to the third party reporting pamphlet and better visibility, and this auditor has recommended the following corrective action items to be completed within six months.

CORRECTIVE ACTION NEEDED:

1. Third party reporting pamphlet must indicate that parents/guardians can request an administrative remedy on behalf of the resident. The pamphlet should be in a place that is more visible to the public and also must be available in other languages than English. The pamphlet should also be located in the visitation area where visitors meet with residents. The facility will submit copies of the revised pamphlets in English and Spanish, and a photo of the prominent location of the handbook to the auditor.

Additional Documentation Reviewed:

- Third Party Reporting Brochures written in English and in Spanish was provided to the auditor. The Brochures have been revised to focus on third party reporting information.
- A photo was submitted to verify that the Third Party Reporting Brochures in English and in Spanish are displayed in an appropriate fashion and area within the master control/visitation lobby.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

Standard 115.353 Resident access to outside confidential support services

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy G-101, Access to Courts and Counsel gives residents the right to their attorneys, guardian ad litem (GAL) and other authorized court representatives through phone or personal visits. Residents are provided with a private area for these visits.

Policy G-101 Rights of Youth was also reviewed.

The agency has a Memorandum of Understanding with Southern Arizona Children's Advocacy Center and the Tucson Police

Department. The MOU provides access to a Forensic Examiner or Sexual Assault Nurse Examiner (SANE) when necessary. The MOU also provides access to counseling and advocacy services for the victim if requested. Both agencies have agreed to provide services for incidents of sexual abuse.

During the facility tour of the living units, PREA information was not displayed in a manner that was beneficial to the residents. The small size of the posters, the random placement of the posters, the lack of immediate PREA education, and the lack of advocate and support services phone numbers, hotline numbers or addresses of these facilities were not in areas that are accessible to residents.

Fifteen residents were interviewed and nine were unaware of the advocacy services, the meaning of the posters and their right to call or write to the advocacy center. It was determined that although residents understood that mandatory reporting laws required certain information to be reported, residents were not aware of how the reporting process worked, what information would be reported, or who the information would be reported too.

The Superintendent stated that the facility provides residents with reasonable and confidential access to their attorneys or other legal representation utilizing private interview rooms and by telephone and that the facility provides residents with reasonable access to parents or legal guardians during non-contact visitation, weekly telephone calls or by approval, written correspondence, or during parent support groups

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No residents who reported sexual abuse were detained and available to interview.

Based on the evidence discussed, the facility has not demonstrated compliance with this standard due to the lack of PREA-related information in the housing units, access to phone numbers, and resident knowledge of the reporting process and this auditor has recommended the following corrective action items to be completed within six months.

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CORRECTIVE ACTION NEEDED:

1. Resident PREA posters for outside victim advocacy services should be prominently displayed in each unit and in larger, more readable print. Copies of posters shall be submitted to the auditor with photos of locations.
2. Residents shall have increased access to phones and other methods of reporting sexual abuse in writing to outside advocacy centers. Access to addresses and phone numbers should be made visible to residents. The facility shall submit a written protocol and any other supporting documentation to the auditor.
3. It was determined that although residents understood that mandatory reporting laws required certain information to be reported, residents were not aware of how the reporting process worked, what information would be reported, or who the information would be reported too. The facility shall submit to the auditor documentation that this information is being discussed with each resident at time of intake.

VERIFICATION OF CORRECTION ACTION:

The Auditor was provided appropriate supplemental documentation on December 19, 2016 to evidence and demonstrate corrective actions taken regarding this standard.

Additional Documentation Reviewed:

- Twenty-two “Zero Tolerance Youth Acknowledgement” forms were submitted between the period of November 6, 2016 and December 15, 2016 for the auditor to sample. The form outlines expectations, how to report, what information is reported, who it will be reported too, and definitions of sexual abuse and harassment. The form also includes acknowledgement that the resident was provided a PREA booklet and that the resident understands the information provided to them. The form is designed to be reviewed by a staff member with the resident and is signed by both staff and resident.
- Photos of PREA informational posters were submitted to the auditor. Photos verified that the posters are visible to residents in living units 100, 200, 300, 400 and 500; classrooms 600, 1100, 1200, 1400, and 1500; master control lobby/visitation area; and in the medical unit. Posters are in English and Spanish and contain information on ways a resident can report sexual abuse and sexual harassment including a hotline number that residents call for victim advocacy services.
- The facility has installed a designated phone for the residents to use privately and timely. This new service has an auto attendant that allows the residents to connect to the Southern Arizona Center Against Sexual Assault Rape Crisis Line.
- Signs are posted near the phone indicating that the phone is a phone not for public use and is located in a private interview room.
- The facility submitted to the auditor an information sheet regarding the logistics of the PREA phone and the PREA report slips/

- Residents have been trained on the new phone system and have signed a form acknowledging they received the information.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has a Third Party Reporting Brochure that gives the public information on how to complete a Third Party Report alleging suspected abuse or harassment. The agency lists a PREA Reporting Line (520-724-9950) for the public to verbally make a PREA report and it has a link "ZeroTolerance@pcjcc.pima.gov" so the public can email a PREA report. The auditor was able to call the number listed on the brochure for the PREA Reporting Line and reached a recording that instructed the caller to leave a report on the voicemail. The auditor also entered the link listed on the brochure and an outlook form came up so a PREA report could be e-mailed to the agency.

During the facility tour, it was observed that the facility does not have the Third Party Brochure displayed in a prominent place where it would be noticeable to the public, such as the public lobby and the visitation area. The pamphlet is also not labeled in a manner that makes it recognizable as an instruction guide to make third party reports. The pamphlet should also include a method for the public or guardian to make an immediate report. There is not a Spanish version of the pamphlet.

The agency does not have a policy or protocol for maintaining and responding to reports made via email or phone.

Based on the evidence discussed, the facility has not demonstrated compliance with this standard due to the third party reporting pamphlet being incomplete, not displayed appropriately, not in a language other than English, and not having a protocol developed for responding to internal reporting measures, and this auditor has recommended the following corrective action items to be completed within six months.

CORRECTIVE ACTION NEEDED:

1. Third party reporting pamphlet to be displayed for public ease and located in all areas where visitors have access too. The pamphlet shall be made available in English and Spanish. A copy of the pamphlet in English and Spanish shall be submitted to the auditor, and a photo of the location of the pamphlets shall be submitted.
2. A protocol for maintaining and responding to internal reporting measures (voice mail and website notifications) shall be developed. A copy of the protocol shall be submitted to the auditor.
3. The facility shall revise the third party reporting pamphlet to focus on specific parent/third party reporting mechanisms as it is geared toward resident viewing, not adult. A copy of the pamphlet shall be submitted to the auditor.

VERIFICATION OF CORRECTION ACTION:
The Auditor was provided appropriate supplemental documentation on December 30, 2016 to evidence and demonstrate corrective actions taken regarding this standard.

Additional Documentation Reviewed:

- Third Party Reporting Brochures written in English and in Spanish was provided to the auditor. The Brochures have been revised to focus on third party reporting information.
- A photo was submitted to verify that the Third Party Reporting Brochures in English and in Spanish are displayed in an appropriate fashion and area within the master control/visitation lobby.
- "Maintaining and Responding to Internal Reporting Measures" Protocol was submitted that details the email and voice

mail reporting mechanisms. The protocol addresses how to maintain internal reporting measures and how to respond to such measures. The protocol contains specific processes and identifies the persons responsible.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

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.

Policy *A-307 PREA* requires all staff to report all suspected and alleged incidents of misconduct. The policy allows 24 hours for such incidents to be reported. Section II Mandatory Reporting states there will be disciplinary actions up to and including termination for anyone who retaliates against a youth or staff for reporting an incident of sexual harassment or abuse. The policy also states that personnel are prohibited from discussing the incident with anyone other than those who need to know.

Policy *B-102 Reporting of Non-Accidental Injury/Neglect of Minor* addresses the notification of the appropriate agency office and the victim's parents or legal guardians. The policy addresses reporting allegations of sexual abuse and sexual harassment including Third Party Reporting and anonymous reporting to the facility.

The following information is not contained in policy:

a. Alleged victim's attorney or legal representative should be informed of the allegation within 14 days if the juvenile court retains jurisdiction of the alleged victim.
b. Any disciplinary actions for those whose negligence or violation of duties may have led to an incidence of sexual harassment or sexual abuse.
c. Staff are prohibited from revealing information regarding sexual abuse to anyone other than the extent necessary.
d. Medical and mental health professionals are required to report sexual abuse to designated supervisors and officials.
e. The responsibility of medical and mental health practitioners of their duty to report sexual abuse to designated supervisors or officials.
f. The requirement of said officials to inform residents of their duty to report and the limitations of confidentiality.

The Reporting Form addresses notification of parents or legal guardians if the parental rights have been severed.

The PREA brochure addresses reporting allegations of sexual abuse and sexual harassment including Third Party Reporting and anonymous reporting to the facility.

Employee training records were reviewed to verify staff received PREA training. Rosters and signed acknowledgement forms were reviewed.

During interviews with random staff, all staff reported that the agency requires staff to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in the facility; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. All staff also stated that they received PREA training as required in 115.331 a through k.

According to interviews with the medical and mental health staff, at the initiation of services to a resident, limitations of confidentiality and duty to report is disclosed and all staff have a responsibility to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment immediately upon learning of it. At time of audit, staff reported that there have been no instances reported.

The Superintendent stated that when the facility receives an allegation of sexual abuse, staff reports it to the Director, Chief, law enforcement, department of child safety, PREA Coordinator, and probation officer. The Director notifies the parent of the victim in a timely manner. This is done as soon as possible and appropriate. Attorneys are notified as well. The Superintendent stated that all allegations of sexual abuse and sexual harassment are reported to the PREA Coordinator and Human Resources for investigation.

Based on the evidence discussed, the facility has not demonstrated compliance with this standard due to policies lacking information, and this auditor has recommended the following corrective action items to be completed within six months.

CORRECTIVE ACTIONS NEEDED:

1. The agency's Mandatory Reporting Policy does not meet the PREA standard of reporting an incident regarding sexual abuse or harassment immediately. The agency allows 24 hours to make a report, while the standard requires immediately. The facility must revise policy and practice to report immediately. The facility shall submit a revised policy to the auditor.
2. Incorporate the responsibility of medical and mental health practitioners to report sexual abuse to designated supervisors and officials into the PREA Policy. This can be incorporated into PREA Policy A-307, p.9 sec. XII Medical, Mental Health and Support Services for Youth. The facility shall submit a revised policy to the auditor.
3. Incorporate the responsibility of medical and mental health practitioners to inform residents of their duty to report and their limitations of confidentiality into the PREA Policy. This can be incorporated into PREA Policy A-307, p.9 sec. XII Medical, Mental Health and Support Services for Youth. The facility shall submit a revised policy to the auditor.
4. The agency policy does not state that the alleged victim's attorney or legal representative should be informed of the allegation within 14 days if the juvenile court retains jurisdiction of the alleged victim. The facility shall submit a revised policy to the auditor.

VERIFICATION OF CORRECTION ACTION:
The Auditor was provided appropriate supplemental documentation on January 3, 2017 to evidence and demonstrate corrective actions taken regarding this standard.

Additional Documentation Reviewed:

- The agency submitted revised "PREA Policy" A-307. The policy includes that sexual abuse and sexual harassment allegations will be reported immediately.
- The agency submitted revised "PREA Policy" A-307. The policy includes the responsibility of medical and mental health practitioners to report sexual abuse to designated supervisors.
- The agency submitted revised "PREA Policy" A-307. The policy includes the responsibility of medical and mental health practitioners to inform residents of their duty to report and their limitations of confidentiality.
- The agency submitted revised "PREA Policy" A-307. The policy now states that the alleged victim's attorney or legal representative will be notified of the allegation within 14 days of receiving the allegation if the court retains jurisdiction.

Based on the evidence discussed, the facility has demonstrated compliance with the 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.

Policy B-102 Reporting of Non-Accidental Injury/Neglect of Minor and policy A-307 *PREA* were reviewed. Neither policy has a written procedure for protecting a youth who is at imminent risk of sexual abuse.

The PREA Coordinator verified during interview that this information is not included in policy.

Based on the evidence discussed, the facility has not demonstrated compliance with this standard due to not having a policy or procedure on standard 115.362, and this auditor has recommended the following corrective action items to be completed within six months.

CORRECTIVE ACTION NEEDED:

1. Facility should develop a policy detailing steps that would be taken to protect youth of imminent sexual abuse once agency is aware of risk. The facility shall submit a revised policy to the auditor.

VERIFICATION OF CORRECTION ACTION:
The Auditor was provided appropriate supplemental documentation on January 3, 2017 to evidence and demonstrate corrective actions taken regarding this standard.

Additional Documentation Reviewed:

- The facility submitted revised "PREA Policy" A-307 that addresses detailed steps that would be taken to protect youth of imminent sexual abuse once the agency becomes aware of the risk.

Based on the evidence discussed, the facility has demonstrated compliance with the 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.

Policy *B-102 Reporting of Non-Accidental Injury/Neglect or Minor Reporting Physical/Sexual Abuse or Neglect* lists procedures for the agency to take when receiving allegations of abuse and neglect that have occurred at the facility.

The facility does not have policies that address:

a. Reporting to other confinement facilities, that the facility head or agency that receives such notifications will ensure that the allegation is investigated.
b. Reporting to other Confinement Facilities.
c. That the head of the agency that received the allegation will notify the head of the facility where the alleged abuse occurred and the appropriate investigative agency.
d. Reporting to other confinement facilities that it will document that it provided such notification.
e. Notification must be provided to the other agency no later than 72 hours after receiving the allegation.

According to the Agency Head, the facility takes immediate protective action by increasing supervision and separating the victim and aggressor and that staff should respond to protect residents at substantial risk of imminent sexual abuse right away. The Agency Head stated the facility will contact the Tucson Police Department should another agency advise the facility of sexual abuse or sexual harassment that occurred within this facility.

The Superintendent stated that the facility would move the perpetrator right away once the facility learned that a resident is subject to a substantial risk of imminent sexual abuse. The Superintendent also stated that when the facility receives an allegation from another facility or agency that an incident of sexual abuse or sexual harassment occurred in the facility they would begin the investigation process right away. To date, the facility has not had such a report.

Randomly interviewed staff stated that they would take appropriate actions to protect the residents. However, during the

interviews staff were inconsistent as to what steps they would take. Four staff reported that they would report it to the chain of command and let them determine what to do; and others stated that they would separate the victim, isolate the victim, or lock the victim down.

Based on the evidence discussed, the facility has not demonstrated compliance with this standard due to missing information from policies, and this auditor has recommended the following corrective action items to be completed within six months.

CORRECTIVE ACTION NEEDED:

1. The facility will include in its policy a procedure that addresses reporting to other confinement facilities, that the facility head or agency that receives such notifications will ensure that the allegation is investigated.
2. The agency will develop a policy and procedure for "Reporting to other Confinement Facilities".
3. The agency shall include in the procedure that the head of the agency that received the allegation will notify the head of the facility where the alleged abuse occurred and the appropriate investigative agency.
4. The agency will include in its policy that addresses reporting to other confinement facilities that it will document that it provided such notification.
5. The agency shall include it in its policy that notification must be provided to the other agency no later than 72 hours after receiving the allegation.

VERIFICATION OF CORRECTION ACTION:
The Auditor was provided appropriate supplemental documentation on January 3, 2017 to evidence and demonstrate corrective actions taken regarding this standard.

Additional Documentation Reviewed:

- The facility submitted revised "PREA Policy" A-307 that addresses the reporting to other confinement facilities. The policy states that at any time PCJDC staff has knowledge of or is suspicious of any sexual abuse or sexual harassment that occurred in any secure facility, including residential facility, will immediately report it to the shift supervisor or Unit One. The shift supervisor will contact law enforcement if sexual abuse is alleged and will contact medical and mental health personnel. The Detention Director or designee will notify the head of the facility or appropriate office of the facility where the alleged sexual harassment or abuse occurred and provide the notification as soon as possible but no later than 72 hours after receiving the allegation.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

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.

Policy *A-307 PREA*, lists the procedures on how to respond to allegations of sexual abuse or harassment. The policy states that anyone receiving an allegation or sexual abuse or harassment or witnessing sexual abuse or harassment is considered a First Responder.

First responder interviews identified that all staff interviewed were unclear as to their first responder responsibilities. All staff stated that they would separate residents; however, all staff interviewed could not state all five actions of a first responder:

a. Separating victim and abuser
b. Preserving and protecting crime scene
c. Requesting that the victim not take any actions to destroy evidence
d. Ensuring that the abuser does not take any actions to destroy evidence

e. Immediately notify medical and mental health practitioners.

Also, during interview, staff understood what a first responder was, however staff were unsure when to report the allegations or who to report the allegations too. Staff also believed that is was the responsibility of the first responder to collect evidence instead of just preserving evidence. Staff interviews suggest that staff are unclear as to what their first responder responsibilities are, who to report an incident too, and who not to share information with.

No residents who reported sexual abuse were detained, therefore unable to be interviewed.

Based on the evidence discussed, the facility has not demonstrated compliance with this standard due to limited understanding of first responder duties of staff, and this auditor has recommended the following corrective action items to be completed within six months.

CORRECTIVE ACTION NEEDED:

1. Staff shall receive training on first responder responsibilities to include:
   a. Separating victim and abuser
   b. Preserving and protecting crime scene
   c. Requesting that the victim not take any actions to destroy evidence
   d. Ensuring that the abuser does not take any actions to destroy evidence
   e. Immediately notify medical and mental health practitioners.

Facility shall submit an agenda and staff sign in roster to auditor to verify training given.

2. Staff training is needed so that staff understands:
   a. How to report an alleged assault,
   b. A timeframe to report the alleged assault,
   c. Who to report the alleged assault to, and
   d. First responder should not attempt to collect evidence; they should only preserve the evidence.

Facility shall submit an agenda and staff sign in roster to auditor to verify training given.

VERIFICATION OF CORRECTION ACTION:
The Auditor was provided appropriate supplemental documentation on December 5, 2016 to evidence and demonstrate corrective actions taken regarding this standard.

Additional Documentation Reviewed:

- Training, Education, and Development Employee Training Sign in Rosters for "PREA First Responder" indicates that fifty employees received training in first responder duties.
- PREA Staff Understanding of Training Presented form for "PREA First Responder Juvenile Detention Officer Training" was completed on December 1, 2016. Each of the fifty employees trained signed an acknowledgement form indicating their understanding of first responder duties.
- First Responder cards were provided to officers to place on their clip or in the wallets that details the steps a first responder shall take in case of a sexual abuse incident occurs.
- First Responder Responsibilities two-page handout was provided to all fifty employees. This handout describes how to report an alleged assault; a timeframe to report the alleged assault; who to report the alleged assault to; and preservation of evidence.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

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.

A-307 PREA Policy, Investigation Process outlines the Agency's institutional plan that coordinates the actions that will be taken in response to an incident of sexual abuse. The Investigation Process defines who the First Responder is and the responsibilities of the First Responder. Expectations include preserving the crime scene, separating the alleged victim and alleged abuser, preserving physical evidence, contacting the Shift Supervisor or designee and Mental and Medical Health Services.

The Shift Supervisor has specific duties listed such as notifying the Division Director, the PREA Coordinator and Law Enforcement. The Division Director will notify the Director of Juvenile Court. The Division Director will then begin the investigation process.

The Superintendent stated that in response to an incident of sexual abuse, the facility's plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership would be to preserve any evidence, and that in unison, everyone would play their parts in the process.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

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

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

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

According to the Agency Head, the agency does not have any collective bargaining agreements.

This standard is not applicable.

Standard 115.367 Agency protection against retaliation

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

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

Policy *A-307 PREA* addresses staff and resident protection against retaliation; monitoring the conduct and treatment of staff

and residents who reported abuse for 90 days for retaliation; a minimum 90 day monitoring must take place after a report of sexual abuse; the agency's obligation to monitor will terminate in the agency determines that the allegation is unfounded; separating the alleged victim and the alleged abuser and ensuring the safety of the alleged victim; and the reassignment of a staff member to another area or placed on administrative leave..

Policy *B-102 Reporting of Non-Accidental Injury/Neglect of Minor* states the alleged victim or reporter of abuse will be protected from retribution by the alleged perpetrator and will have access to medical and mental health services and outside victim advocates.

Policy C-501 Room and Welfare Checks states youth kept separate from the population for their own protection will be closely monitored.

Room and Welfare Checks logs were reviewed and are completed accurately and consistently.

According to the Agency Head, residents and staff are protected from retaliation for sexual abuse or sexual harassment allegations by separation and monitoring behaviors. If an individual who cooperates with an investigation expresses fear of retaliation, the agency will take immediate protective measures, such as separating one from another, relocating staff, and monitoring behaviors frequently.

The Superintendent stated that for allegations of sexual abuse or sexual harassment, the measures the facility would take to protect residents and staff from retaliation would be to move units, check in regularly and document. The agency would also review files and staff assignments, as well as monitor and take appropriate personnel actions. The Superintendent stated that if the facility suspects retaliation, that they would take appropriate steps, such as placing an employee on administrative leave, or re-assigning them to a different work location. The Superintendent also stated that for allegations of sexual abuse or sexual harassment, the measures the facility would take to protect residents and staff from retaliation would be to move units, check in regularly and document. The agency would also review files and staff assignments, as well as monitor and take appropriate personnel actions. The Superintendent also stated that if the facility suspects retaliation, that they would take appropriate steps, such as placing an employee on administrative leave, or re-assigning them to a different work location.

According to interviews with staff charged with monitoring retaliation, staffs role in preventing retaliation against residents and staff who report sexual abuse or sexual harassment, or against those who cooperate with sexual abuse or sexual harassment investigations is to assure fairness in that no punitive action will be taken and to provide oversight. Measures that staff would take to protect those residents and staff from retaliation would include reading the file and incident reports, observing to ensure staff and residents are not treated poorly, and to watch the natural flow. The staff charged with monitoring retaliation maintains daily contact with residents who have reported sexual abuse. According to interviews with staff charged with monitoring retaliation, staff looks at privileges being taken away from residents, residents being sent to their rooms, resident performance and discipline issued to detect possible retaliation. The designated staff will monitor as long as it takes or until the threat is over.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

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.

Policy *A-307 PREA* discusses the use of segregated housing and the requirement to use isolation or segregation per guidelines of 115.342.

The Superintendent stated that no isolation is used.

Medical and mental health staff report that isolation of residents has never been used in the facility.

No residents in isolation were available to interview; however during random interviews with residents, all fifteen residents stated that they have never been held in isolation for any reason.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

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.

Policy *A-307 PREA* states that:

a. The administrative investigator will conducts an investigation of alleged sexual abuse and harassment confidently, promptly, thoroughly and objectively.
b. All administrative investigators will have special training in sexual abuse investigations pursuant to standard 115.334.
c. The investigator will gather and preserve direct and circumstantial evidence, physical and DNA and electronic monitoring data.
d. The investigator will conduct an interview with the victim and the investigator will conduct an interview with the alleged offender and consider prior complaints and reports of sexual abuse involving the alleged offender.
e. If a youth recants or declines to participate in the investigation or leaves the facility, the alleged PREA incident will still be investigated.
f. If at any time during the investigation, the quality of the evidence appears to support criminal prosecution; the Agency will consult with the prosecutors as to whether interviews may be an obstacle for later criminal prosecution.
g. The alleged victim will never be subjected to a polygraph exam as a condition for proceeding with an investigation.
h. The credibility of the alleged victim; suspect or witness shall be assessed on an individual basis and not based on a person's status.
i. The final report will include whether personnel actions or failures to act facilitated the abuse. Paragraph B also includes that the final report will include a summary of allegations, statements from youth, personnel, and witnesses, physical and testimonial evidence.
j. Criminal investigations shall be documented in a written report and will include statements from youth, personnel and all witnesses and physical and testimonial evidence. Criminal Investigations will also include physical and DNA evidence.
k. At any time during the investigation, the quality appears to support criminal prosecution, the Director of Juvenile Court Services with consult with the prosecutors.
l. All written reports will be retained for as long as the abuser is incarcerated or sill employed, plus 5 years, unless the abuser was a detained youth and applicable law require a shorter retention period; and it states the investigation will continue even if the alleged perpetrator leaves the facility.

Documentation was reviewed and verified by roster and training certificate that the PREA Coordinator received training specific to conducting sexual abuse and sexual harassment investigations in confinement settings by taking the Department of Justice PREA Investigations training. The topics included 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 or prosecution referral.

The agency has a Memorandum of Understanding (MOU) with the Tucson Police Department to conduct its investigations when necessary. A copy of MOU with Tucson Police Department was available for review.

The Superintendent stated that the Tucson Police Department investigates allegations of sexual abuse and that the facility reaches out to them regularly by phone and email. This contact is documented. An update on status is provided to the victim and documented.

According to the PREA Coordinator, she is designated the internal investigative staff. The PREA Coordinator stated that the response time to initiate an investigation following an allegation of sexual abuse or sexual harassment is immediate. Once an allegation is made, staff reports it to the PREA Coordinator. In turn, the PREA Coordinator gathers the facts, reviews video, if applicable, and notifies the Tucson Police Department. According to the PREA Coordinator, anonymous and third party reports are not handled differently and that third party reports are also investigated thoroughly and objectively. The PREA Coordinator only conducts non-criminal internal investigations. All other investigations are referred to the Tucson Police Department for investigation.

The PREA Coordinator stated that the first steps would be to confirm with the victim what happened, collect the facts, review video, and report it to the Tucson Police Department. The Tucson Police Department is responsible for DNA collection, interviews, and evidence collection. The PREA Coordinator stated that the investigation does not terminate if the source of the allegation recants his/her allegation. The PREA Coordinator stated that they do not consult with prosecutors as they do not conduct compelled interviews. The Tucson Police Department will be contacted to conduct such interviews.

The PREA Coordinator stated that the Tucson Police Department is responsible for judging the credibility of an alleged victim and is also responsible for arranging polygraph examination. The PREA Coordinator states that staff investigations are documented in the employees personnel file and that documentation would consist of a thorough description as well as any documentary evidence. The PREA Coordinator stated that should an employee allege to have committed sexual abuse or sexual harassment terminate his/her employment prior to a completed investigation, that investigation will continue. The PREA Coordinator stated that the Tucson Police Department refers cases for prosecution.

According to the PREA Coordinator if an outside agency investigates allegations of sexual abuse, the agency will remain informed of the progress of a sexual abuse investigation by communicating regularly with Tucson Police Department and documenting. The facility will keep the victim updated on the status of the case. The PREA Coordinator stated that when Tucson Police Department investigates an allegation, the role of the PREA Coordinator is to cooperate with the investigator and monitor the situation internally, keeping the victim safe at all times.

No residents that reported sexual abuse were detained, therefore could not be interviewed.

Based on the evidence discussed, the facility has exceeded compliance with this standard by having a coordinated response and a multi-agency collaborative agreement in place.

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.

Policy *A-307 PREA* states that the agency shall impose no standard higher than the preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

According to investigative staff, the internal investigator is the PREA Coordinator. The PREA Coordinator stated that the standard of evidence required substantiating allegations of sexual abuse or sexual harassment is determined by the Tucson Police Department. A thorough explanation of the referral process and standard of evidence can be found in standards 115.321 and 115.371.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy *A-307 PREA* states:

a. The agency will inform the residents or staff in writing if the outcome of an investigation is founded, substantiated, unfounded or inconclusive.
b. A youth will be informed as to whether the allegation has been substantiated, unsubstantiated or unfounded.
c. Addresses allegations against another youth.
d. The agency will inform the victim when the alleged abuser has been indicted or convicted of a charge related to sexual abuse within the facility.
e. Obligation to report ceases once the youth is released from custody.
f. If law enforcement handles the investigation, the PREA Coordinator will have ongoing communication, document the contact and inform the youth of the progress.
g. Allegations against a staff member the agency will inform the youth with the staff member is no longer working the resident's unit and if the staff member is no longer employed with the agency, or indicted or convicted on a charge related to sexual abuse within the facility.

The Superintendent stated that the facility notifies a resident who makes an allegation of sexual abuse, that the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation.

According to investigative staff, the internal investigator is the PREA Coordinator. The PREA Coordinator stated that when a resident makes an allegation of sexual abuse, he or she must be informed as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation.

There were no residents detained that reported sexual abuse to interview.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy *A-307 PREA* states that staff will be subject to disciplinary actions including termination for violating the agency's PREA Policy; that those in violation of the policy and statutes shall be subject to corrective action; and that criminal allegations against personnel will be forward to law enforcement. The policy mentions that staff are subject to termination if they have engaged in sexual abuse and the policy also incorporates staff's disciplinary history, circumstances and nature of the acts committed and sanctions given to other staff members who committed a similar offence when considering disciplinary sanctions. Additionally, the policy addresses terminations due to violations of sexual assault and harassment, reporting to law enforcement, administrative investigations and completing investigations even if the staff resigns.

There were no files of personnel with disciplinary actions to review.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy *A-307 PREA* states any contractor of volunteer who engages in sexual abuse will be prohibited from contact with youth and will be reported to law enforcement and other relevant licensing bodies. The policy also states that the agency will make the decision to prohibit a contractor or volunteer from having contact with youth.

There were no files of contractors and volunteers with disciplinary actions to review.

The Superintendent stated that in the case of any violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, the facility would take remedial measures and prohibit further contact with residents.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

Standard 115.378 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy *A-307 PREA* addresses disciplinary sanctions for youth who youth that have engaged in resident on resident sexual abuse. It also addresses disciplinary sanctions being commensurate with the nature and circumstances of the abuse committed, the youth's discipline history, sanctions imposed for comparable offenses by other youth and the youth's mental disabilities and health. The policy addresses discipline for a youth who initiates non-consensual sexual contact with a staff member and it addresses reports made in good faith based on a reasonable believe that inappropriate conduct occurred will

not be considered false reporting even if the allegation is unsubstantiated. The PREA Policy prohibits sexual activity between youth, but will not consider it sexual abuse if the contact was not coerced. In addition, the policy states that the disciplinary process will consider a youth's mental disabilities or mental illness when determining the type of sanction to be imposed. Policy also states that the facility does not provide counseling or other interventions to address and correct underlying motivations for abuse.

The policy does not address therapy or other interventions designed to address underlying reasons or motivations for abusive behavior and shall include the option to participate in a behavior management system/program.

There were no files of contractors and volunteers with disciplinary actions to review.

The Superintendent stated that residents would be subject to disciplinary sanctions following an administrative or criminal finding the resident engaged in resident on resident sexual abuse. Sanctions would be based on the resident's age, mental concerns, and history. Isolation would not be used.

According to medical and mental health staff, the facility offers therapy, counseling, and other intervention services designed to address and correct the underlying reasons or motivations for sexual abuse. Services are offered to the victim and the offender. When providing these services, a resident's participation as a condition of access to programming, education, and rewards-based behavior management systems is not required.

Based on the evidence discussed, the facility has not demonstrated compliance with this standard due to missing information from policy addressing therapy and other interventions, and this auditor has recommended the following corrective action items to be completed within six months.

CORRECTIVE ACTION NEEDED:

1. Policy must address therapy or other interventions designed to address underlying reasons or motivations for abusive behavior and shall include the option to participate in a behavior management system/program. Facility shall submit a copy of the policy to the auditor.

VERIFICATION OF CORRECTION ACTION:
The Auditor was provided appropriate supplemental documentation on January 3, 2017 to evidence and demonstrate corrective actions taken regarding this standard.

Additional Documentation Reviewed:

- The facility submitted a revised "PREA Policy" A-307 that addresses the referral to therapy or the provision of interventions to assist in addressing the underlying reasons or motivations for abusive behavior.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

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.

Policy *A-307 PREA* states all youth who have experienced sexual abuse will receive follow up treatment with Mental and Medical Health Services. The policy states that youth who may be abusers will have mental health evaluations by the appropriate mental heal professionals and the policy limits information related to sexual abuse or sexual victimization to Medical or Mental Health Professionals and other personnel as necessary to inform for treatment plans and security and

management decisions. Policy also states that no consent is required for all residents are under the age of 18. Additionally, the policy states that someone who reports a prior history of sexual abuse should receive follow-up treatment with mental health and medical services within 14 days of their intake.

Random samples of Classification and Detainment Forms for residents were reviewed and the auditor was able to verify that youth were being referred for medical/mental health treatment.

Interviews with staff responsible for risk screening also confirmed that youth were being referred for medical/mental health treatment and that if a screening indicates that a resident has experienced prior sexual victimization, whether in an institutional setting or in the community, a follow-up meeting with a medical or mental health practitioner is provided. According to interviews, staff reported that if a screening indicates that a resident previously perpetrated sexual abuse, a follow-up meeting with a mental health practitioner would be provided. Staff would refer the resident to the counselor and report to the department of child safety.

No residents who disclosed sexual victimization at risk screening were detained, therefore could not be interviewed.

Medical and mental health staff state that staff are mandatory reporters and that informed consent from residents before reporting about prior sexual victimization that did not occur in an institutional setting is not required.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

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.

Policy *A-307 PREA* states that Medical and Mental Health Professionals will be notified and the victim will be treated or transported to a medical center if necessary. The victim is also offered advocacy services and crisis intervention. The policy offers emergency contraception, STI prophylaxis and pregnancy testing, when medically appropriate and that all treatment services to the victim are without financial cost.

The Medical, Mental Health and Support Services does not include in its policies steps to take if a medical or mental health professional is not available and the victim is need of immediate care. The First Responder Policy also does not address steps to take if a youth is in need of immediate medical care and medical/mental health professionals are not available. Both policies work on the assumption that medical/mental health professionals will be readily available.

Medical and mental health staff state that victims of sexual abuse are offered timely information about access to emergency contraception and sexually transmitted infection prophylaxis. Medical keeps contraception in stock and provides STD testing.

Medical and mental health staff stated that resident victims of sexual abuse receive timely and unimpeded access to emergency medical treatment and crisis intervention services. Medical staff and the counselor respond immediately to all situations. The nature and scope of services are determined according to staff's professional judgment.

No residents who reported sexual abuse were detained.

Based on the evidence discussed, the facility has not demonstrated compliance with this standard due to not having a policy in place that addresses imminent danger and proper notifications, and this auditor has recommended the following corrective action items to be completed within six months.

CORRECTIVE ACTION NEEDED:

1. Facility to develop a policy that addresses imminent danger and procedure to take when medical or mental health providers are unavailable. Policy and procedure shall include the proper notifications to make and who the contact person is in case of an emergency. The facility shall provide a copy of the policy to the auditor.

VERIFICATION OF CORRECTION ACTION:
The Auditor was provided appropriate supplemental documentation on January 3, 2017 to evidence and demonstrate corrective actions taken regarding this standard.

Additional Documentation Reviewed:

- The facility submitted revised "PREA Policy" A-307 that addresses detailed steps that would be taken to protect youth of imminent sexual abuse once the agency becomes aware of the risk. The policy also addresses that medical and mental health staff are available 24/7.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

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.

Policy *A-307 PREA* states that the facility will offer medical and mental health evaluations and treatment when appropriate to all youth have been victimized by sexual abuse. The policy also states that the facility will provide follow up services, mental health services, treatment plans that are consistent with community level care and if necessary referral for continued care when released. The policy addresses youth will be provided with medical and mental health services consisted with community level care. Policy states that victims of vaginal penetration will be offered pregnancy test. According to policy, victims of sexual abuse who become pregnant will receive timely and comprehensive information about access to all lawful pregnancy related medical services. Policy also states that residents of sexual abuse will receive tests for sexually transmitted infections when medically appropriate; and included in the policy, the victim will be provided with medical treatment without financial costs. Additionally, the policy addresses all known youth abusers will have a mental health evaluation within 60 days.

According to medical and mental health staff, evaluation and treatment of residents who have been victimized entails emergency response, first aid application, and a complete trauma screening and mental health assessment. Medical staff works closely with the local child advocacy center. Medical and mental health staff stated that medical and mental health services are consistent with community level of care. Victims are referred to the Southern Arizona Child Advocacy Center for exams. Medical and mental health staff stated that if pregnancy results from sexual abuse while incarcerated, victims are given timely information and access to all lawful pregnancy-related services. This information is provided to residents immediately by medical staff. Medical and mental health staff stated that a mental health evaluation of all known resident-on-resident abusers is conducted and treatment, if appropriate, is offered. Medical staff report that residents are never placed in isolation.

No residents who reported sexual abuse were detained, therefore, unable to be interviewed. . No female residents who reported sexual abuse were detained and available for interview.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

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.

Policy *A-307 PREA* states that the agency will conduct incident reviews for all sexual abuse investigations including when the allegation has not been substantiated. Policy states that the facility will conduct the interview within 7-10 days of the conclusion of the incident and that the facility's review team includes upper level management, line supervisors, investigators, and medical and mental health professionals.

Policy *A-307 PREA* the Sexual Abuse Review Team will consider if policy and procedures needs to be changed; consider what the motivation for the abuse was; determine if the physical layout of the facility contributed to the abuse; if staffing levels contributed to the abuse; and if better technology is needed. Policy also states that the PREA Coordinator will implement the recommendations or document why they could not be implemented.

The PREA Coordinator stated that she will prepare a report of the findings that will be provided to the incident review team.

The Superintendent stated that the facility has a sexual abuse incident review team in place and that the SART team uses information from the sexual abuse incident review. The review team considers 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 and/or group dynamics. The team examines the area in the facility where the incident allegedly occurred. The team assesses the adequacy of staffing levels in that area and assesses whether monitoring technology should be deployed or augmented to supplemental supervision by staff.

According to a member of the incident review team, the review team

a. Considers 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 was motivated or otherwise caused by other group dynamics at the facility.
b. Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse.
c. Assess the adequacy of staffing levels in that area during difference shifts.
d. Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

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.

Policy *A-307 PREA* states the agency will aggregate the incident-based data annually. Also policy states that the agency will review and collect data from available incident based documents, including reports, investigative files and sexual abuse incident reviews, and that it will provide all data to the Department of Justice no later than June 30th of the calendar year.

The agency's website does not contain any documented sexual abuse statistics.

According to the PREA Coordinator, the agency does not have a means of collecting accurate, uniform, incident based data as required by the Department of Justice to answer questions from the Survey of Sexual Violence and that the agency does not maintain, review and collect data as needed from reports, investigations and sexual abuse incident reviews.

The Agency Head stated that the facility does not contract with other agencies for the confinement of its residents.

Based on the evidence discussed, the facility has not demonstrated compliance with this standard due to not having a means of collecting accurate, uniform, incident based data as required by the Department of Justice to answer questions from the Survey of Sexual Violence and that the agency does not maintain, review and collect data as needed from reports, investigations and sexual abuse incident review, and this auditor has recommended the following corrective action items to be completed within six months.

CORRECTIVE ACTION NEEDED:

1. Aggregated sexual abuse data must be collected annually. A completed data report that meets requirements set forth in standard 115.387 to be submitted to auditor.
2. The facility shall develop and use a standardized instrument and set of definitions to collect accurate and uniform data for all sexual abuse allegations. A completed data report that meets requirements set forth in standard 115.387 (comparable to the Survey of Sexual Violence) to be submitted to auditor.

VERIFICATION OF CORRECTION ACTION:
The Auditor was provided appropriate supplemental documentation on January 5, 2017 to evidence and demonstrate corrective actions taken regarding this standard.

Additional Documentation Reviewed:

- The facility submitted a PREA Data report that contains data for reporting years 2015 and 2016. The report contains aggregated data for each year. The facility reported that there were zero instances of sexual abuse and sexual harassment allegations over the past two years, to include substantiated, unsubstantiated, and unfounded. The report answers questions from the Survey of Sexual Violence.
- The auditor verified that the report is now available on the agency's website: http://www.pcjcc.pima.gov/HTML%20files/Divisions/Detention/PREA.html

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

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 agency has not included in its policy that it will redact specific material from its reports when publication may present a safety and security threat. The nature of the material being redacted must be indicated.

The agency does not have a report comparing sexual abuse statistics or a documented corrective action plan that is at is available to the public.

The facility does not have documentation that it is collecting data to assess and improve the effectiveness of its sexual abuse prevention, detention and response policies, practices and training. The agency does not have a report that compares the current year's data and corrective actions with previous years to provide an assessment of the agency's progress in addressing sexual abuse.

According to the Agency Head, the facility reviews every incident report that is written. They revise policies and procedures every two years and as necessary. According to the Agency Head, annual reports will be made available and approved by the Agency Head.

The PREA Coordinator stated that she will facilitate meetings where corrective action plans can be discussed. According to the PREA Coordinator, the agency does not 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, and training. The agency does not prepare an annual report of its findings from its data review and any corrective actions. According to the PREA Coordinator, any identifying information would be redacted from the annual report.

Based on the evidence discussed, the facility has not demonstrated compliance with this standard due to the facility not collecting and reviewing data or having a policy that addresses such procedures, and this auditor has recommended the following corrective action items to be completed within six months.

CORRECTIVE ACTION NEEDED:

1. Aggregated sexual abuse data must be collected annually. A copy of the report must be provided to the auditor.
2. The facility shall develop and use a standardized instrument and set of definitions to collect accurate and uniform data for all sexual abuse allegations. A copy of the standardized instrument must be provided to the auditor.
3. The agency shall include in policy that it will redact information that poses a safety and security threat. It must also indicate the nature of the material being redacted. A copy of the policy will be submitted to the auditor.
4. Data review for corrective action to include identifying problem areas, taking corrective action, and preparing an annual report. Agency shall submit a written protocol for collecting such information and documentation to the auditor.
5. The agency shall develop a report that will compare the current year's data with the data from previous years to assess the agency's progress in addressing sexual abuse. A copy of the report must be provided to the auditor.
6. Annual report must be made available to public annually through website or other means. The annual report shall include comparable abuse statistics and corrective actions plans that detail the progress that has been made concerning sexual abuse. The facility shall advise auditor where the information can be located.

VERIFICATION OF CORRECTION ACTION:
The Auditor was provided appropriate supplemental documentation on January 3, 2017 and January 5, 2017 to evidence and demonstrate corrective actions taken regarding this standard.

Additional Documentation Reviewed:

- PREA Policy A-307 includes information regarding the redaction of personal identifiers from reports before publication. The revised policy contains written protocol for identifying problem areas, taking corrective action, and preparing an annual report.
- The facility submitted a PREA Data report that contains data for reporting years 2015 and 2016. The report contains aggregated data for each year. The facility reported that there were zero instances of sexual abuse and sexual harassment allegations over the past two years, to include substantiated, unsubstantiated, and unfounded. The report answers questions from the Survey of Sexual Violence.
- The auditor verified that the report is now available on the agency's website: http://www.pcjcc.pima.gov/HTML%20files/Divisions/Detention/PREA.html
- The report contains action items that were accomplished and/or still in process of being completed for 2015 and 2016.

Based on the evidence discussed, the facility has demonstrated compliance with the standard.

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.

A-307 PREA Policy states the agency does not include a time limit on maintaining sexual abuse data. The policy also states that all written reports will be retained for as long as the abuser is incarcerated or still employed, plus 5 years, unless the abuser was detained youth and applicable law requires shorter retention period.

The agency does not have a policy that states all collected data will be securely retained.

According to the PREA Coordinator, the agency does not 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, and training. Additionally, the agency has not made all aggregated sexual abuse data available to the public. .

Based on the evidence discussed, the facility has not demonstrated compliance with this standard due to not maintaining data for ten years, and not having policies in place that addresses the storage, publication, and destruction of data, and this auditor has recommended the following corrective action items to be completed within six months.

CORRECTIVE ACTION NEEDED:

1. The facility shall include in its policy and procedure that is will maintain sexual abuse date collected pursuant to standard 115.387 for at least 10 years. Facility will provide auditor with revised policy.
2. Policy must address that aggregated sexual abuse data from facilities under its direct control be made readily available to the public, at least annually, through its website. Facility will provide auditor with revised policy.
3. The facility shall write a policy and procedure to ensure that data collected pursuant to standard 115.387 is securely retained. Facility will provide auditor with revised policy.
4. The facility shall collect and make all aggregated sexual abuse data available to the public. The facility can do this by including its sexual abuse data on its current website that has its PREA policy and Third Party reporting information on it. This information shall be made available to the public on an annual basis. The facility shall provide auditor with the website address where information can be located.
5. The facility shall write a policy and procedure to ensure that all data collected pursuant to standard 115.387, will have all personal identifiers removed. Facility will provide auditor with revised policy. The policy states that data collected will be retained for at least 10 years.

VERIFICATION OF CORRECTION ACTION:
The Auditor was provided appropriate supplemental documentation on January 3, 2017 and January 5, 2017 to evidence and demonstrate corrective actions taken regarding this standard.

Additional Documentation Reviewed:

- The facility submitted a revised PREA Policy A-307 that now includes data review, storage, publication, and destruction procedures.
- PREA Policy A-307 includes information regarding the redaction of personal identifiers from reports before publication. The revised policy contains written protocol for identifying problem areas, taking corrective action, and preparing an annual report.
- The facility submitted a PREA Data report that contains data for reporting years 2015 and 2016. The report contains aggregated data for each year. The facility reported that there were zero instances of sexual abuse and sexual harassment allegations over the past two years, to include substantiated, unsubstantiated, and unfounded. The report answers questions from the Survey of Sexual Violence.
- The auditor verified that the report is now available on the agency's website:

http://www.pcjcc.pima.gov/HTML%20files/Divisions/Detention/PREA.html

- The report contains action items that were accomplished and/or still in process of being completed for 2015 and 2016.

Based on the evidence discussed, the facility has demonstrated compliance with the 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 inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Elaine Bridschge March 1, 2017

Auditor Signature Date