



October 28, 2016

Charles Gatwood, Administrator
Eastern Arizona Regional Juvenile Detention Facility
919 Thatcher Blvd.
Safford, Arizona 85546

Re: PREA Audit – Final Report

Dear Mr. Gatwood:

On July 28 and 29, 2016 a Prison Rape Elimination Act audit was conducted at your facility. Nine PREA standard deficiencies were identified and documented in the PREA Audit Interim Report. These deficiencies placed your facility into the Corrective Action process.

PREA Coordinator, Eric Gore, provided the documentation required to verify correction of the deficiencies found in the initial audit and documented in the Interim PREA Audit Report. The attached Final Audit Summary Report reflects the corrections and accompanies this letter. The report indicates that Eastern Arizona Regional Juvenile Detention Facility is in full compliance with PREA standards. The Final PREA Audit Summary Report must be publicly provided on the Agency website or otherwise made available to the public per PREA Standard 115.403 (f).

Congratulations on achieving compliance on your Agency's first PREA audit. Should there be any questions or concerns, please feel free to contact me.

A handwritten signature in black ink that reads "Elaine Brideschge". The signature is written in a cursive, flowing style.

Elaine Brideschge, Certified PREA Auditor
Rising Sun Auditing Service, LLC

Attachment: Eastern Arizona Regional Juvenile Detention Facility Final PREA Audit Summary Report

PO Box 66
Valley Farms, AZ 85191
Phone: 520-866-7074
Email: ebridsch@courts.az.gov

PREA AUDIT REPORT INTERIM x FINAL
JUVENILE FACILITIES

Date of report: October 28, 2016

Auditor Information			
Auditor name: Elaine Brideschge			
Address: PO Box 66 Valley Farms, AZ 85191			
Email: ebridsch@courts.az.gov			
Telephone number: 520-705-6610			
Date of facility visit: 07/28-29/2016			
Facility Information			
Facility name: Eastern Arizona Regional Juvenile Detention Facility			
Facility physical address: 919 Thatcher Blvd., Safford, AZ 85546			
Facility mailing address: <i>(if different from above)</i> N/A			
Facility telephone number: 928-428-3954			
The facility is:	<input type="checkbox"/> Federal	<input type="checkbox"/> State	<input checked="" type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input type="checkbox"/> Private not for profit		
Facility type:	<input type="checkbox"/> Correctional	<input checked="" type="checkbox"/> Detention	<input type="checkbox"/> Other
Name of facility's Chief Executive Officer: Charles Gatwood			
Number of staff assigned to the facility in the last 12 months: 20			
Designed facility capacity: 51			
Current population of facility: 11			
Facility security levels/inmate custody levels: Maximum			
Age range of the population: 9-18			
Name of PREA Compliance Manager: Amberlynn Bailey		Title: Detention Officer	
Email address: abailey@graham.az.gov		Telephone number: 928-792-5300	
Agency Information			
Name of agency: Eastern Arizona Regional Juvenile Detention Facility			
Governing authority or parent agency: <i>(if applicable)</i> Graham County			
Physical address: 919 Thatcher Blvd, Safford, AZ 85546			
Mailing address: <i>(if different from above)</i> N/A			
Telephone number: 928-428-3954			
Agency Chief Executive Officer			
Name: Charles Gatwood		Title: Administrator	
Email address: cgatwood@graham.az.gov		Telephone number: 928-792-5300	
Agency-Wide PREA Coordinator			
Name: Eric Gore		Title: Sergeant	
Email address: egore@graham.az.gov		Telephone number: 928-428-3954	

AUDIT FINDINGS

NARRATIVE

The PREA onsite audit of the Eastern Arizona Regional Juvenile Detention Facility (EARJDF) in Safford Arizona was conducted on July 28 and 29, 2016 by Elaine Brideschge, 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.

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 two day period: July 28 and 29, 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, Compliance Manager, specialized staff, random staff, youth, etc.).

An extensive facility tour was conducted which included observation of facility configuration, staff supervision of residents, housing, intake, classrooms, medical unit, visitation areas, 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. The auditor was able to review log books maintained by master control, and view PREA-related education materials and placement of posters throughout the facility. 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 four housing units. The auditor was escorted by the PREA Coordinator.

Eleven residents were identified on the facility roster as being detained. Out of the eleven detained residents, one was removed from the facility and taken to the hospital for a medical emergency. The auditor was able to interview seven residents. The residents were selected randomly by the auditor using a current roster of residents. The auditor selected a minimum of one from each of the four housing units, a minimum of one from each gender, and a minimum of one that met the criteria of disabled and limited English proficient. 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, 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.

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 that was provided by the PREA Coordinator. The Auditor randomly selected at a minimum of one officer 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, 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 in person or by phone, a volunteer, a contractor, SAFE/SANE staff, victim advocates, intermediate or higher-level facility staff, the facility administrator/agency head, PREA Coordinator, and the 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 a sample of resident case records, 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 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, a phone interview was conducted with a representative from Mt. Graham Safe House. A phone interview was also held with a representative from Tucson Hospital that provides SAFE/SAFE practitioners.

On the final day of the onsite audit, a two-hour 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 Eastern Arizona Regional Juvenile Detention Facility (EARJDF) a designed capacity of 51 beds, located in Safford Arizona. Forty-three are single occupancy sleeping rooms and four are double occupancy sleeping rooms. The facility consists of one single building with four housing units. A toilet and sink is located within in each sleeping room (cell) where residents can access privately and out of view. The population is made up of both male and female residents, with a designated female unit. The EARJDF houses both county and U.S. Marshal residents ages 9-18. Graham County provides secure juvenile detention services to two other surrounding counties through a contractual agreement. No residents older than 18 years of age are detained. The facility is considered maximum security. Residents are secured with mechanical restraints when leaving the facility.

The building contains an administration area which is directly accessible through the main entrance. The main entrance is controlled by the master control. A telephone is located outside the main entrance for visitors to use to be able to access the facility. Once verified, master control will allow entrance into the facility. The facility is controlled by locking doors that is controlled by master control. The auditor observed during the tour that the only door controlled by key is the master control room and the key is maintained from within the control room. The school and medical units are located within the single building. The school has two classrooms and a general area used as a library. The medical unit is a single room containing a desk for the nurse, an exam table within the room, and locked cabinets for pharmaceutical supplies and other miscellaneous items. There is one nurse assigned to the detention facility at any given time. Small recreation yards, with concrete floors displaying artwork from detained youth in the form of wall murals, are adjacent to each of the four housing unit. Each housing unit contains a common day room that is used for eating meals, and programming.

The facility is small in size and has a separate area for intake and processing. This area has a bathroom that is used for strip searches. The facility also contains a supply room that was observed locked by the auditor. There is a newly placed camera that has the supply room in direct view. The Superior Courthouse where residents are seen by the Judge is located within walking distance from the facility. The facility implements direct podular supervision, where staff can visually supervise residents. Programming is conducted daily by staff in the housing units. Residents have access to onsite medical and mental health services. Visitation is available four days per week. Attorney visits can occur daily.

The average length of stay for a resident in the EARJDF is 10 days. At time of audit, 11 residents, 10 male and 1 female, were detained. One resident was taken off site for a medical emergency. The facility currently has sixteen staff employed at the facility, and three authorized volunteers and contractors. Due to the Juvenile Detention Alternative Initiative (JDAI) through the Casey Foundation, residents detained at any given time is very 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 provided and prepared by a licensed entity outside of the facility and are not prepared onsite.

SUMMARY OF AUDIT FINDINGS

In the past 12 months, EARJDF reported that no allegations of sexual abuse or sexual harassment were received; thus, there were zero administrative investigations and zero criminal investigations related to sexual abuse or sexual harassment conducted at EARJDF.

Overall, the interviews of residents reflected that they were aware of and understand the PREA protections and the agency's zero tolerance policy. 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. At time of intake, residents are provided with comprehensive education on PREA that includes personal instruction in addition to a 30 minute orientation video. Residents indicated that they understood the various ways to report abuse and discussed the posters throughout the facility with the telephone number to call to report sexual abuse or harassment. 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. Staff was knowledgeable about their roles and responsibilities in the prevention, reporting, and responding to sexual abuse and sexual harassment. Additionally, staff were well trained on the first responder's protocol for any PREA related allegation and staff could clearly articulate exactly the steps they would follow if they were the first responder to an incident.

The auditor was able to confirm that an agreement was in place with Mt. Graham Safe House to provide rape crisis intervention services. Further, the auditor spoke with a representative from Tucson Hospital that confirmed they provide SAFE's/SANE's forensic services for victims of sexual abuse.

In summary, after reviewing all pertinent information and after conducting resident and staff interviews, the auditor found that the department and agency leadership have clearly made PREA compliance a high priority and have devoted sufficient time and resources to staff training and education of residents on all the key aspects of PREA. The Administrator, Mr. Charles Gatwood, was professional, well respected by staff, and has a strong positive presence at the facility. It was repeatedly demonstrated throughout the two-day on-site visit that Mr. Gatwood makes himself readily available to staff; that residents and staff respect and trust him; and that he is committed to keeping residents safe and helping residents make positive changes in their lives. It was also confirmed through observation and staff and resident interviews, that Mr. Gatwood assists staff and residents whenever they are in need (i.e. responds to emergency situations, assists with maintaining ratio).

Number of standards exceeded: 2

Number of standards met: 30

Number of standards not met: 9

Number of standards not applicable: N/A

OCTOBER 2016 UPDATE SINCE THE AUDIT: CORRECTION ACTIONS TAKEN BY EARJDF TO ACHIEVE FULL COMPLIANCE

The Interim Compliance Report reflected there were nine standards that were in non-compliance at the EARJDF. Therefore, a required corrective action period not to exceed 180 days began on September 13, 2016. The Auditor recommended a corrective action plan for the facility and the administration agreed and began immediate corrections of those standards found to be in non-compliance. EARJDF completed the required corrective actions requested by the Auditor to bring the program into full compliance with the PREA standards. Documentation of the corrective actions were received by the auditor on October 20, 2016. The Auditor reviewed the submitted documentation to determine if full compliance with the standards were achieved. After reviewing all documentation, the Auditor determined that the EARJDF administration has demonstrated compliance with and full institutionalization of the PREA standards. Therefore, the Auditor determined that the program has achieved full compliance with the PREA standards as of the date of this final report.

FINAL COMPLIANCE:

Number of standards exceeded: 3

Number of standards met: 38

Number of standards not met: 0

Number of standards not applicable: N/A

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 entitled "PREA Prevention Planning" mandates zero tolerance toward all forms of sexual abuse and sexual harassment in the facility 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. The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment and it includes sanctions for those found to have participated in prohibited behaviors. The policy includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents.

During the facility tour, zero tolerance posters were observed throughout the facility, to include housing units, education, and medical. Zero tolerance is included in the youth handbook that is given to every resident at time of intake. Resident testimonials during interviews confirmed that youth understands the facility's zero tolerance policy.

The agency employs an upper level, agency-wide PREA Coordinator that reports directly to the Facility Administrator. Interviews with the PREA Coordinator and Facility Administrator confirms that the PREA Coordinator has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards. This is included in the Facility policy entitled "PREA Prevention Planning". The facility Organizational Chart revised January 2015 appropriately identifies the PREA Coordinator, Eric Gore, reporting directly to the Facility Administrator, Charles Gatwood.

Even though Eastern Arizona Regional Juvenile Detention Facility operates only one facility, they elected to also appoint a Detention Officer, Amberlynn Bailey, as the PREA Compliance Manager. The facility Organizational Chart shows that the PREA Compliance Manager reports directly to the PREA Coordinator. Interviews with the PREA Coordinator and the Compliance Manager, and in review of the shift/staff schedule affirms that the PREA Compliance Manager and the PREA Coordinator work opposite of each other to provide a PREA point of contact for each shift seven days a week. The PREA Compliance Manager, during interview, stated that she has sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards.

Standard 115.312 Contracting with other entities for the confinement of residents

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

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

In review of documentation, prior to August 20, 2012, an intergovernmental agreement (IGA) number 08-11-0032 dated March 14, 2012, was developed and signed between Graham County and the U.S. Marshal's Service for the confinement of the U.S. Marshal's Service juveniles. Interview with the Facility's Contract Administrator indicates that on or after August 20, 2012, the facility has not entered into any new contracts or contract renewals.

Standard 115.313 Supervision and monitoring

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

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

The facility reports the average daily number of residents is 10 and the average daily number of residents on which the staffing plan was predicated is 10. According to interviews with the Facility Administrator and the PREA Compliance Manager, the facility has a developed staffing plan that provides for adequate levels of staffing. During the tour of the facility, the Auditor observed ratio to be within the 1:8 ratio in the waking hours and 1:16 in the sleeping hours. The Auditor reviewed the Staffing Plan submitted by the agency and found it to be sufficient with the average daily population of residents they have. A log book is maintained by the Master Control Officer that indicates each time the staffing plan is not complied with, noting the reasons or justification. It should be noted that there were no entries in the log. In interview with the Master Control Officer, he indicated that to his knowledge, ratio has always been met. The facility provides over time to employees to ensure ratio is observed. During the onsite visit, the Auditor observed a medical emergency that required two employees to leave with a resident. During the emergency, the Facility Administrator and PREA Coordinator stepped in to supervise the residents to assure ratio was met. According to the Facility Administrator and PREA Coordinator, the facility is obligated by Arizona State Detention Standards to maintain staffing ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours. The Auditor was able to review the state detention standards and found this to be accurate.

The facility appointed the PREA Coordinator and the PREA Compliance Manager as the intermediate-level or higher-level staff to conduct unannounced rounds to identify and deter staff sexual abuse and sexual harassment. This was verified during interviews with the PREA Coordinator and the PREA Compliance Manager. The facility's policy entitled "PREA Prevention and Planning" states that the facility prohibits staff from alerting other staff of the conduct of such rounds. The facility policy also states "The Administrator or designee shall regularly conduct and document unannounced rounds". Another facility policy 04-04.4 "Juvenile and Facility Searches" state that "frequent, unannounced searches are conducted." Staff interviews with the PREA Coordinator and the PREA Compliance Manager revealed that staff designated to conduct the unannounced rounds are uncertain as to the purpose and intent of such rounds. The Auditor found that the two policies mentioned above contradict one another as to the intent of the unannounced rounds, referring to the unannounced rounds as "rounds" in one policy, and "searches" in the other policy. During staff interviews, staff revealed that for the most part they were unaware when rounds were occurring but didn't know they were for PREA compliance. A log book is maintained in Master Control that documents such rounds with date and time. The rounds occur once per shift according to the PREA Compliance Manager. According to the PREA Compliance Manager, should her or the PREA Coordinator be absent from a shift, the welfare checks may not occur. Video was not available for review demonstrating unannounced rounds have occurred.

During the interviews with the PREA Coordinator and Facility Administrator, the facility assesses, determines, and documents whether adjustments are needed to the staffing plan, staffing patterns, video monitoring systems, and available resources to ensure adherence to the staffing plan. Annual reports were reviewed during document review by the Auditor. The facility recently installed several new cameras throughout the facility, to include additional cameras in the housing units, intake, administration, and education. One video surveillance camera was observed in each of the recreation yards that are located adjacent to each of the four housing units. During the tour the PREA Coordinator advised the Auditor that there were still areas that needed either additional cameras or relocation/realignment of cameras due to blind spots, specifically in the each of the recreation yards. This was not noted in the most recent facility staffing plan or the most recent facility's Annual PREA Report. Blind spots in each recreation yard was verified by the Auditor by observing the cameras in Master Control and during interview with the Master Control Officer. A large section in each recreation yard is not viewable on camera. The PREA Coordinator advised the Auditor that they may be able to replace the lenses of the cameras for a wider angle.

CORRECTIVE ACTION NEEDED:

1. Facility policy "PREA Prevention and Planning" and facility policy #04-04.4 "Juvenile and Facility Searches" contain contradictory information pertaining to unannounced rounds. The Facility should revise both policies to reflect that the facility has intermediate-level and higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse

and sexual harassment. The policy should reflect the procedure the facility has taken to ensure that rounds are conducted on every shift daily, and in the absence of the PREA Coordinator and the PREA Compliance Manager. The policy should also be clear that the facility prohibits staff from alerting other staff of the conduct of such rounds.

2. The Facility Administrator or designee shall provide training to the intermediate-level or higher-level staff on the purposes and procedures of unannounced rounds and document such training on a roster and training log.
3. To enhance the agency's ability to protect youth from sexual abuse, blinds spots on the recreation yards should be eliminated by adding additional cameras or modifying existing cameras.

VERIFICATION OF CORRECTIVE ACTION SINCE THE AUDIT

The Auditor was provided supplemental documentation on October 20, 2016 to evidence and demonstrate corrective actions taken by the EARJDF administration regarding this standard. This documentation is discussed below.

Additional Documentation Reviewed:

Policy "PREA Prevention and Planning"
Policy 04-04.4 "Juvenile and facility Searches"
Policy 03-16 "Searches of Persons and Facility"
2016 Unannounced Rounds Training Sign In Sheet
Invoices for modified camera lenses

Summary

THE EARJDF revised policy "PREA Prevention Planning" and policy 03-16 "Searches of Persons and Facility" to reflect consistency between the two policies in regards to the facility having intermediate-level and higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment. The policies now reflect the procedure the facility has taken to ensure that rounds are conducted on every shift daily, and in the absence of the PREA Coordinator and the PREA Compliance Manager. It is clearly stated in the policy that the facility prohibits staff from alerting other staff of the conduct of such rounds.

The facility provided training to staff on the topic of unannounced rounds. The training was given by Mr. Charles Gatwood, Detention Administrator and was provided in small groups between the periods of October 11, 2016 through October 14, 2016. Staff trained signed the name to a training sign in sheet to verify training was received.

On August 7, 2016 the facility modified existing cameras located in each recreation yard by purchasing and installing six 2.8mm CCTV Board Camera Fixed Lens and six 2.1mm CCTV Board Camera Fixed Lens which allows for a wider angle of viewing capabilities to eliminate blind spots on the recreation yards.

The EARJDF is now fully compliant with this 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 #04-04.4 "Juvenile and Facility Searches" states that strip searches are to be conducted by two officers when it is possible to do so. This policy does not address cross gender searches and does not specify that the two officers must be of the same gender of the resident. This policy does not include strip searches of transgender or intersex residents. Policy #03-37.4 "Sexual Misconduct, Sexual Abuse/Assault Reporting Requirements and Child Abuse Reporting Requirements" states that cross gender supervision in non-emergency situations where juveniles disrobe or perform bodily functions should be limited. Non-medical staff involved in cross-gender strip or visual

searches indicated during interviews that they conduct a two person strip search and that at times a staff of the opposite gender may be the second staff person. Staff also indicated that the second staff person is present, however not in direct contact of the resident. During resident interviews, residents reported that staff of the opposite gender has not seen them undressed in full view. Facility policy entitled “PREA Prevention Planning” states that cross gender physical searches are prohibited. During the tour, strip searches were not observed by the Auditor. Medical staff reported that they do not conduct strip searches or cavity searches. In case a cavity search is needed, the resident is transported to the local hospital where medical staff would conduct the search. The facility reported that the number of cross-gender pat-down searches of residents is zero and residents that did not involve exigent circumstances is zero. Logs of strip searches are maintained by staff.

Staff interviews indicate that staff were not trained, or insufficiently trained, on how to conduct cross gender pat and strip searches, and searches of transgender and intersex youth. Training records dated 02/27/2015 and training curriculum were reviewed and reflected that 100% of facility staff have received training in conducting strip and pat searches, however the curriculum did not cover searches of transgender or intersex residents.

The facility policy entitled “PREA Prevention Planning”, section C, states that “All youth are permitted to shower, perform bodily functions, and change clothing without nonmedical staff viewing their genitals, buttocks, breasts (female), except in the case of emergency, by accident, or performing routine cell or room checks.” Upon observation of the facility, each housing unit contains shower stalls where residents can shower separately and privately. Resident interviews confirm that they shower alone and privately. Toilets are provided in each sleeping room (cell) and residents are housed single cell, with no roommate to ensure privacy when using the restroom.

The same policy states that “Staff of the opposite gender when entering housing units must announce their presence to alert youth.” Interviews with staff indicate that they announce their presence when entering a housing unit. Five residents interviewed stated that staff of the opposite gender are inconsistent with announcing their presence and that some staff do it regularly while others do not do it at all. They also stated that during evening and night hours, staff of the opposite gender are less likely to announce their presence. During the facility tour, the Auditor did not witness staff of the opposite gender announcing their presence when entering a housing unit.

Facility policy entitled “PREA Prevention Planning” prohibits staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident’s genital status. The facility reports that zero searches occurred in the past 12 months and that the facility has not detained a transgender or intersex resident. Interviews with random staff conclude that they do not search or examine residents for the purpose of determining genital status.

CORRECTIVE ACTION NEEDED:

1. All three policies identified above shall be revised to eliminate the conflicting information pertaining to searches, specifically pat and strip searches, and contain the proper procedure for strip and pat searches of transgender and intersex youth.
2. Staff training on proper techniques and protocols for conducting pat and strip searches, specifically of transgender and intersex youth, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security need, should be provided and documented on a training roster and training certificate. Curriculum should also be submitted to the Auditor for review.
3. Facility staff were inconsistent announcing their presence when entering a housing unit. Staff shall be trained and training documented by curriculum, training roster, and training log. The PREA Coordinator and PREA Compliance Manager should monitor staff and interview residents to assure compliance with this standard.

VERIFICATION OF CORRECTIVE ACTION SINCE THE AUDIT

The Auditor was provided supplemental documentation on October 20, 2016 to evidence and demonstrate corrective actions taken by the EARJDF administration regarding this standard. This documentation is discussed below.

Additional Documentation Reviewed:

Policy “PREA Prevention Planning”

Policy 04-04.4 “Juvenile and Facility Searches”

Policy 03-16 “Searches of Persons and Facility”

2016 Guidance on Cross-Gender and Transgender Pat Searches Training Sign In Sheet

Guidance in Cross-Gender and Transgender Pat Searches Curriculum

Summary

The facility revised policies “PREA Prevention Planning”, 04-04.4 “Juvenile and Facility Searches”, and 03-16 “Searches of Persons and Facility” to eliminate the conflicting information pertaining to searches, specifically pat and strip searches, and now contain the proper procedure for strip and pat searches of transgender and intersex youth.

The facility provided training to staff of the guidance on cross-gender and transgender pat searches. The training was delivered in a facilitated video format, in which the PREA Resource Center video and curriculum were utilized. Training was provided in small groups between the periods of August 1, 2016 through August 9, 2016. Staff trained signed the name to a training sign in sheet to verify training was received. The training curriculum was developed in 2015 by the Moss Group for the PREA Resource Center.

The EARJDF is now fully compliant with this 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.

In review of facility policy entitled “PREA Prevention Planning” section E, the agency has established procedures to provide disabled residents equal opportunity to participate in or benefit from all aspects of the agency’s efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The PREA Coordinator stated during the interview, and confirmed during resident interviews, that the agency employs a number of bilingual staff to assist with daily communication with English Language Learners. This was also observed by the Auditor during the facility tour. Graham County Superior Court has a contract with interpreters and provides the facility with a Language Access Plan (LAP) that describes in detail the process the facility will take to ascertain an interpreter. Documentation reviewed consisted of alternative language youth handbooks and posters which are located throughout the facility.

Documentation of staff training on PREA compliant practices for residents with disabilities, to include training logs and curriculum, were reviewed and found to meet these criteria.

According to the interview with the Agency Head, Charles Gatwood, the agency has established procedures 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 resident interviews, all residents reported that the facility provided them with information about sexual abuse and sexual harassment that they were able to understand and that they received the information at time of intake.

During random staff and resident interviews, they reported that the facility does not allow residents to interpret for another resident. Facility policy entitled “PREA Prevention Planning” section E #5 states “Interpretation services may be provided by a bilingual officer or staff member who speaks the same language as the juvenile, but shall not be provided by another juvenile. The interpreter must be able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary.”

The facility reports that in the last 12 months, there has been zero number of instances where resident interpreters, readers, or other types of resident assistants have been used and it was not the case that an extended delay in obtaining another interpreter could compromise the resident’s safety, the performance of first-response duties, or the investigation of the resident’s allegations.

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.

Facility policy entitled “PREA Prevention Planning” prohibits hiring or promoting anyone who may have contact with residents, and prohibits enlisting the services of any contactor 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.

Facility policy requires the consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. The practice was confirmed during the interview with the administrative staff over Human Resources, Charles Gatwood.

The facility’s policy (mentioned above) also requires that before it hires any new employees who may have contact with residents, it (a) conducts criminal background records checks, (b) consults with any child abuse registry maintained by the State or locality in which the employee would work; and (c) consistent with Federal, State, and local law, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. This was verified through interview with Charles Gatwood.

The facility reported that during the past 12 months three persons were hired that may have contact with residents had criminal background checks. The Auditor verified that 100% of persons hired who may have contact with residents did have criminal record checks performed and that the record checks were consistent with this standard and questions regarding past conduct were asked and answered.

The facility consults with the State Of Arizona Child Abuse Registry before enlisting the services of any contactor who may have contact with residents or hiring any employee. During the interview with Charles Gatwood, he stated that no formal contract is needed with the State of Arizona Child Abuse Registry. There is an agreement with Graham County Sheriff Office to conduct the criminal history background record checks on potential employees.

Review of facility policy (mentioned above) and interview with Charles Gatwood confirm that the agency policy requires that criminal background records checks be conducted at least every five years of current employees and contractors who may have contact with residents. The facility policy also states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

In interview with Charles Gatwood, the facility will provide information on substantiated allegations of sexual abuse and harassment involving a former employee to an employer for whom such employee has applied to work.

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.

Interviews with the Facility Head, Charles Gatwood, and the PREA Coordinator, Eric Gore, indicated that the facility has not made a substantial expansion or modification to existing facility since August 12, 2012. During the tour of the facility, the PREA Coordinator advised the Auditor that video surveillance cameras have been added throughout the facility to enhance the agency's ability to protect youth from sexual abuse by eliminating blind spots. This was not noted in the facility staffing plan, meeting minutes, or the facility's annual PREA Report.

The PREA Coordinator also advised the Auditor that blind spots on all recreation yards still exist. This was verified through random staff interviews and by observing the camera system in Master Control. During this observation of cameras, the Auditor noted a portion of each of the four recreation yards were not visible by camera, nor was the camera able to pan out. There is one camera mounted in each recreation yard. Additionally, two of the residents advised the Auditor that they were aware that there were places, specifically on the recreation yard, where they are not on camera.

Documentation of the facility design/layout was submitted and reviewed by the Auditor prior to the onsite portion of the audit.

CORRECTIVE ACTION NEEDED:

1. The Facility shall replace, add, or modify existing cameras on each recreation yard to ensure that residents are protected. This can be verified through receipts of installation or a signed statement from the installation company.

VERIFICATION OF CORRECTIVE ACTION SINCE THE AUDIT

The Auditor was provided supplemental documentation on October 20, 2016 to evidence and demonstrate corrective actions taken by the EARJDF administration regarding this standard. This documentation is discussed below.

Additional Documentation Reviewed:

Invoices for modified camera lenses

Summary

On August 7, 2016 the facility modified existing cameras located in each recreation yard by purchasing and installing six 2.8mm CCTV Board Camera Fixed Lens and six 2.1mm CCTV Board Camera Fixed Lens which allows for a wider angle of viewing capabilities to eliminate blind spots on the recreation yards.

The EARJDF is now fully compliant with this 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.

The Facility refers all allegations of sexual abuse, including resident-on-resident sexual abuse or staff sexual misconduct to the Graham County Sheriff's Office (GCSO). The Facility Administrator stated that when conducting a sexual abuse investigation, GCSO follows a uniform evidence protocol and that it is developmentally appropriate for youth and adopted from the most recent edition of the DOJ's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents". Post onsite visit, the Auditor contacted GCSO and was provided a copy of the uniform evidence protocol.

Based on interviews with the PREA Coordinator and the Facility Administrator, the facility and/or GCSO refer residents who experience sexual abuse within the facility to the local Mt. Graham Hospital. It was reported that this hospital does not have Sexual Assault Forensic Examiners (SAFE's) or Sexual Assault Nurse Examiners (SANE's) onsite and must transport the resident to Tucson Hospital located approximately two hours away from the Mt Graham Hospital. In request of documentation, the facility does not have an memorandum of understanding, documented efforts, or other written documentation with Mt Graham Hospital or Tucson Hospital to ensure that all residents who experience sexual abuse have access to forensic medical examinations whether onsite or at an outside facility, without financial cost, where evidentiary or medically appropriate. A post onsite audit interview was conducted with Tucson Hospital. They verified that they do not have an agreement in place with the Facility and do not recall any conversations occurring with the Facility. They also stated that they have SAFE's and SANE's available in case a forensic medical examination is needed.

During the past 12 months, the facility reports that zero forensic medical exams were conducted, and zero exams were performed by SAFE's/SANE's, and that zero exams were performed by a qualified medical practitioner.

The facility utilizes the Mt. Graham Safe House, a local rape crisis center, to provide victim advocate services. The Auditor received a copy of a memorandum of understanding (MOU) detailing the expectations of services. During the interview with the PREA Compliance Manager, Amberlynn Bailey, she explained that residents are referred to Mt. Graham Safe House in Safford, Arizona, and that the rape crisis center provides victim advocate services. She also referred to the MOU that is in effect. There were not any residents detained at time of onsite visit that reported sexual abuse to interview.

A post onsite visit interview was placed with Debra Dorman, Facilities Manager, at Mt. Graham Safe House. Ms. Dorman stated that Mt. Graham Safe House will provide a victim advocate to accompany and support the victim through the forensic medical examination process and investigatory interviews and provide emotional support, crisis intervention, information, and referrals.

The Facility relies on Graham County Sheriff's Office to conduct investigations of sexual abuse. In interview with the Facility Administrator, Charles Gatwood, and the PREA Coordinator, Eric Gore, the understanding of expectations to provide victims of sexual abuse with SAFE's/SANE's and victim advocacy is a verbal agreement. No written documentation in the form of a memorandum of understanding or documentation of best efforts was available.

CORRECTIVE ACTION NEEDED:

1. Written documentation between Facility, Mt. Graham Hospital, and Tucson Hospital delineating responsibilities of outside medical and mental health practitioners and to corroborate that all resident victims of sexual abuse have access to forensic medical examinations shall be secured.
2. Written documentation between Facility and Graham County Sheriff's Office delineating responsibilities of outside medical and mental health practitioners and to corroborate that all resident victims of sexual abuse have access to forensic medical examinations shall be secured.

VERIFICATION OF CORRECTIVE ACTION SINCE THE AUDIT

The Auditor was provided supplemental documentation on October 20, 2016 to evidence and demonstrate corrective actions taken by the EARJDF administration regarding this standard. This documentation is discussed below.

Additional Documentation Reviewed:

Memorandum of Understanding between EARJDF, Graham County Sheriff's Office, and the Southern Arizona Advocacy Center.

Summary

The facility established a multiagency memorandum of understanding (MOU between EARJDF, Graham County Sheriff's Office, and the Southern Arizona Advocacy Center. Contained in the MOU, is a multidisciplinary team approach to sexual abuse investigations in compliance with PREA. Responsibilities are clearly outlined for each agency in the MOU. The MOU was signed by all parties.

The EARJDF is now fully compliant with this 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.

Facility policy entitled “PREA Reporting, Responding, and Data Collection” governs the investigations for all allegations of sexual abuse and sexual assault and ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. The policy also requires that allegations of sexual abuse and sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior.

The facility reports that in the past 12 months there have been nine allegations of sexual abuse or sexual harassment, three of which resulted in an administrative investigation, and six referred for criminal investigation. The Facility reported that all allegations received in the past 12 months, administrative or criminal investigations were completed. In interviews with the Facility Administrator and PREA Coordinator, allegations were referred to the Graham County Sherriff Office for investigations and when GCSO investigation does not indicate criminal behavior, the findings are turned over to the Facility for administrative review.

The Facility provided documentation of reports of sexual abuse and harassment and documentation of investigations, including full investigative reports with findings.

The Auditor verified that the Facility’s policy (mentioned above) regarding the referral of allegations of sexual abuse or sexual harassment for a criminal investigation is published on the agency website. The policy describes investigative responsibilities of both the agency and the separate entity, Graham County Sheriff’s Office that conducts criminal investigations for the agency.

The Facility provided documentation of all referrals of allegations of sexual abuse or sexual harassment for criminal investigation.

Standard 115.331 Employee training

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

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

The Facility policy entitled “Training and Education” states that the Facility trains all employees who may have contact with residents on the following required matters:

1. It’s zero-tolerance policy for sexual abuse and sexual harassment;
2. How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;
3. Residents’ right to be free from sexual abuse and sexual harassment;
4. The right is residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment;
5. The dynamics of sexual abuse and sexual harassment in juvenile facilities;
6. The common reactions of juvenile victims of sexual abuse and sexual harassment;
7. How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents;
8. How to avoid inappropriate relationships with residents;
9. How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender

- nonconforming residents;
- 10. How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities; and
- 11. Relevant laws regarding the applicable age of consent.

Documentation of training curriculum was reviewed by the Auditor and found to sufficiently include all 11 required areas. Training is tailored to the unique needs and attributes of residents of juvenile facilities and to the gender of the residents at the facility. Training rosters were reviewed and verified that 100% of facility employees receive annual training on PREA requirements. Interviews with random staff confirm that they receive PREA training every year in the 11 required areas. Additionally, upon employees receiving PREA-related training, they document their understanding and comprehension of the training on an Acknowledgement Form. Samples of the Acknowledgement Forms were verified by the Auditor and through staff interviews.

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.

Contractor and volunteer interviews indicate that training is conducted per policy entitled “Training and Education”. Policy states 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, detention, and response. Contractors and volunteers were able to answer PREA-related questions and refer back to training materials that they had received.

The facility reports that 100% of volunteers and contractors, who have contact with residents, have been trained in the agency’s policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response.

The Facility provided the training curriculum for verification. Additionally, all contractors and volunteers are required to sign a form acknowledging that they understand the training they have received. Training records were verified. The facility also supplies contractors and volunteers with a PREA handbook. The handbook was made available to the Auditor for review. Posters located in administration and on the facility’s visitor sign in log provides contractors and volunteers with information on the facility’s zero-tolerance policy.

During interviews with the PREA Coordinator and volunteers and contractors, the facility invites all contractors and volunteers to participate in detention staff annual training. Interviews also confirm that they have been notified of the agency’s zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

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.

Interviews with intake staff suggest that during the intake process, residents receive information related to the facilities zero tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. The facility reports that in the past 12 months, 142 residents were admitted to the facility and 100% of residents received PREA information during time of intake.

The facility also reported that 142 residents admitted during the past 12 months, or 100%, received comprehensive education within 10 days of intake. Intake staff reported that comprehensive education is completed during the intake process and includes a verbal discussion of PREA-related information and residents view a PREA video. During interview with residents, they reported watching a video on PREA and recall having a discussion with the intake officer about zero-tolerance and how to report sexual abuse and sexual harassment. Intake records of residents entering the facility within the last 12 months were provided to the Auditor for review. The education is documented in the residents file.

Residents are provided a PREA youth handbook in English or in Spanish, depending on their primary language. Interviews with residents confirm that they received the handbook and are allowed to keep it with them in their possession during their entire stay. Residents and the PREA Coordinator also reported that staff read the handbook to them in their primary language.

During the tour, the Auditor observed posters regarding zero-tolerance and how to report located throughout the facility, to include housing units and visitation. Intake records of residents entering the facility and forms used at intake were spot checked by the Auditor. Logs with resident signatures corroborating that they received PREA information during intake was reviewed by the Auditor.

Facility policy entitled “Training and Education, section B, describes resident education in detail and also states that residents who are transferred from one facility to another be educated regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents to the extent that the policies and procedures of the new facility differ from those of the previous facility. During resident interviews, the auditor interviewed one resident who was recently transferred from another facility. The resident reported that staff reviewed PREA with him thoroughly and explained everything to him in detail.

The facility also makes information regarding PREA and PREA-related resources, such as STD information, readily available to youth through handbooks, visible posters, and flyers. During a tour of the facility, the Auditor was able to verify that resident PREA education is available in accessible formats for all residents, including those with disabilities and English language learners.

Standard 115.334 Specialized training: Investigations

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

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

The facility does not perform any sexual abuse investigations and refers all allegations to the Graham County Sheriff’s Office for investigation.

Facility policy entitled “Training and Education, section D, requires that investigators are trained in conducting sexual abuse investigations

in confinement settings. Interviews with the facility Administrator and PREA Coordinator confirm that the Graham County Sheriff's Office (GCSO) conducts the sexual abuse investigations and that GCSO investigators are trained in conducting such investigations, to include techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.

Standard 115.335 Specialized training: Medical and mental health care

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

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

The Auditor examined the Facility policy entitled "Training and Education" and verified that it contains all required elements. Policy states that all full-time and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in:

1. How to detect and assess signs of sexual abuse and sexual harassment;
2. How to preserve physical evidence of sexual abuse;
3. How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and
4. How and to whom to report allegations or suspicions of sexual abuse and sexual harassment.

The Facility reports that 100% of medical and mental health care practitioners who work regularly at the facility received training required by agency policy. Interviews with the facility's Nurse and Counselor and review of training records confirm that training was received in all the required elements. Medical and mental health staff also attends the facility's annual training. This was verified through training logs provided by the Nurse and Counselor.

Interview with the facility's medical staff, PREA Coordinator, and Facility Administrator confirms that medical staff at the facility does not conduct forensic exams. Forensic exams are provided by SAFE's/SANE's at the Tucson Hospital.

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.

Facility Policy entitled "PREA Screening for Risk of Sexual Victimization and Abusiveness" requires screening upon admission to the Facility (or transfer from another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents. The policy

also requires that residents be screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their intake. The Facility reports that in the past 12 months, 100% of the 114 residents entering the facility whose length of stay in the facility was over 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. The policy also requires that resident's risk level be reassessed periodically throughout their confinement.

Records for residents admitted to the facility within the past 12 months were reviewed for evidence of appropriate screening within 72 hours. Staff responsible for completing the Risk Screening was interviewed. All staff stated that the Risk Assessment is completed at time of intake. Resident interviews verified that the Risk Assessment is completed during the intake process. Documentation was reviewed of the Risk Assessment tool used. The tool is a validated screening tool adopted by the State of Arizona Office of the Courts. The Screening Tool ascertains, at minimum, the following information:

1. Prior sexual victimization or abusiveness;
2. Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse;
3. Current charges and offense history;
4. Age;
5. Level of emotional and cognitive development;
6. Physical size and stature;
7. Mental illness or mental disabilities;
8. Intellectual or developmental disabilities;
9. Physical disabilities;
10. The resident's own perception of vulnerability; and
11. Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents.

Interviews with staff responsible for conducting the Risk Screening indicated that the information above is ascertained through conversations with the resident during the intake process and medical and mental health screenings. Staff stated that information is also gathered during classifications assessments, and by reviewing court referrals/records, case files, facility behavioral health records, and any other documentation from the resident's files.

The Facility policy (mentioned above) indicates that information obtained during the screening process is used for its designated purpose, and appropriate confidentiality is observed to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents.

Standard 115.342 Use of screening information

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

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

Interviews with staff responsible for the Risk Screening and PREA Coordinator conclude that the Facility uses information from the risk screening required by standard 115.341 to inform housing, bed, work, education, and programs assignments with the goal of keeping all residents safe and free from sexual abuse. Documentation of the use of the Risk Screening information for these purposes was verified by the Auditor. The Facility has four housing units that are used for housing, bed, and programming assignments. There are also two separate classrooms that are utilized for this purpose. Documentation for risk-based housing decisions is documented on the Risk Screening Tool. A random sample was reviewed by the Auditor.

Facility policy entitled "PREA Screening for Risk of Sexual Victimization and Abusiveness" states that detention staff will use the information obtained during the intake process to classify all juveniles, and place them into an appropriate housing units and cells, with the PREA Audit Report

goal of keeping all residents safe and from sexual abuse. Policy also states that lesbian, gay, bisexual, transgender, or intersex residents shall not be placed in a particular room or unit, solely on the basis of such identification or status, nor shall detention officers consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. When determining assignments for a transgender or intersex resident, the determining factor to be considered is whether a placement would ensure the residents health and safety, and if this would present management or security problems. The policy also states that a great deal of consideration in determination of where to place the resident should be vested in where the resident would feel the safest.

Interviews with the PREA Coordinator and staff responsible for risk screening support compliance in regard to program assignments being made on a case-by-case basis. Support is also shown for transgender and intersex youths own views being considered for these program assignments. The Facility reported that there were no lesbian, gay, bisexual, transgender, or intersex residents detained at time of the onsite visit.

As required by standard 115.342, the Facility policy “PREA Screening for Risk of Sexual Victimization and Abusiveness” does not address: 115.342 (b): Residents may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged. During any period of isolation, the facility shall not deny residents daily large-muscle exercise and any legally required educational programming or special education services. Residents in isolation shall receive daily visits from medical or mental health care clinicians. Residents shall also have access to other programs and work opportunities to the extent possible.

The Facility reports that in the past 12 months zero residents at risk of sexual victimization were placed in isolation. Interviews were conducted with the staff who supervise residents in isolation and the Facility’s medical staff. All staff interviewed stated that residents are not placed in isolation. There was no documentation to review to support or disclaim. Residents reported to the Auditor that they were never held in isolation during their stay in detention.

As required by standard 115.342, the Facility policy “PREA Screening for Risk of Sexual Victimization and Abusiveness” does not address: 115.342 (e): Placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident.

The PREA Compliance Manager stated that they have not reassessed any residents. No documentation of reassessment of programming assignments was available to the Auditor for review.

As required by standard 115.342, the Facility policy “PREA Screening for Risk of Sexual Victimization and Abusiveness” does not address: 115.342 (g): Transgender and intersex residents shall be given the opportunity to shower separately from other residents.

During the tour of the facility, the Auditor observed that the showers are private and allows for only one resident to shower at a time. A shower in the intake areas is also available to any resident who requests to shower in a more private area. Resident interviews confirm they shower separately from other residents.

As required by standard 115.342, the Facility policy “PREA Screening for Risk of Sexual Victimization and Abusiveness” does not address: 115.342 (h): If a resident is isolated pursuant to paragraph (b) of section 115.342, the facility should clearly document: (1) The basis for the facility’s concern for the resident’s safety; and (2) The reason why no alternative means of separation can be arranged.

No case files of residents at risk of sexual victimization who were held in isolation in the past 12 months were available for review. According to the PREA Compliance Manager, no residents are held in isolation.

As required by standard 115.342, the Facility policy “PREA Screening for Risk of Sexual Victimization and Abusiveness” does not address: 115.342 (i): Every 30 days, the facility shall afford each resident described in paragraph 115.342 (h) a review to determine whether there is a continuing need for separation from the general population.

No documentation of 30 day reviews was available for review. Again, according to the PREA Compliance Manager, no residents are held in isolation.

CORRECTIVE ACTION NEEDED:

1. The Facility policy entitled “PREA Screening for Risk of Sexual Victimization and Abusiveness” shall be revised to include 115.342 (b), 115.342 (e), 115.342 (g), 115.342 (h), and 115.342 (i) (notated in the summary above). Documentation to meet this standard shall be the revised policy.

VERIFICATION OF CORRECTIVE ACTION SINCE THE AUDIT

The Auditor was provided supplemental documentation on October 20, 2016 to evidence and demonstrate corrective actions taken by the EARJDF administration regarding this standard. This documentation is discussed below.

Additional Documentation Reviewed:

Policy “PREA Screening for Risk of Sexual Victimization and Abusiveness”

Summary

The facility revised policy “PREA Screening for Risk of Sexual Victimization and Abusiveness” to include:

115.342 (b): Residents may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged. During any period of isolation, the facility shall not deny residents daily large-muscle exercise and any legally required educational programming or special education services. Residents in isolation shall receive daily visits from medical or mental health care clinicians. Residents shall also have access to other programs and work opportunities to the extent possible.

115.342 (e): Placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident.

115.342 (g): Transgender and intersex residents shall be given the opportunity to shower separately from other residents.

115.342 (h): If a resident is isolated pursuant to paragraph (b) of section 115.342, the facility should clearly document: (1) The basis for the facility’s concern for the resident’s safety; and (2) The reason why no alternative means of separation can be arranged.

115.342 (i): Every 30 days, the facility shall afford each resident described in paragraph 115.342 (h) a review to determine whether there is a continuing need for separation from the general population.

The EARJDF is now fully compliant with this 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.

Facility policy entitled “PREA Reporting, Responding, and Data Collection” states that the facility shall provide multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.

During the tour of the facility and through interviews with random staff, PREA Coordinator, and residents, the Auditor identified several ways residents can report:

1. Posters are located in each housing unit providing youth with hotline numbers that they can call. It was observed that a telephone is located within each housing unit in the general area that youth can request to use. Through discussion with the PREA Coordinator, it was identified that phone calls can only be made collect. Staff interviewed did not know if the hotline numbers provided to the residents accept collect calls. This would make it difficult for residents to use the phone to report privately. The PREA Coordinator advised the Auditor that residents can request to use a phone in a more private setting, such as intake or medical.
2. Residents can request a confidential report form from an officer to complete a place in a box secured to the wall in each housing unit labeled “PREA”. After discussion with staff and interviews with residents, it was determined that the box labeled “PREA” makes reporting not very private when officers and other residents can observe a resident placing a note in the PREA drop box.
3. A flyer is posted in the housing unit for residents detained solely for civil immigration purposes containing information on how to contact relevant consular officials of the Department of Homeland Security.
4. The PREA Youth Handbook contains contact information for external reporting mechanisms.
5. Residents can also report privately to families during daily visitation, their attorney, or counselor.

Facility policy entitled “PREA Reporting, Responding, and Data Collection” mandates that staff accept reports of sexual abuse and sexual
PREA Audit Report

harassment made verbally, in writing, anonymously, and from third parties. Facility reports that staff are required to document verbal reports within 8 hours of receiving the report. Incident Reports are used by staff to document such reports. This was verified by the Auditor through documentation review and staff interviews.

Facility policy (mentioned above) has established procedures for staff to privately report sexual abuse and sexual harassment of residents. Staff can speak to the PREA Coordinator or the Facility Administrator privately to report any allegations.

CORRECTIVE ACTION NEEDED:

1. A reporting mechanism and tools needed to report sexual abuse and harassment should be available to youth in such a way that they can report privately and confidentially. For instance, the PREA labeled drop box could be removed and the residents can use the general drop box that is used for medical referrals. This way, other residents will not know if it is a medical or PREA-related report.
2. Efforts should be made to determine if the hotline crisis centers accept collect calls. If they do not, youth and staff should be made aware of the protocol needed for youth to place a call to crisis centers privately and confidentially.

VERIFICATION OF CORRECTIVE ACTION SINCE THE AUDIT

The Auditor was provided supplemental documentation on October 20, 2016 to evidence and demonstrate corrective actions taken by the EARJDF administration regarding this standard. This documentation is discussed below.

Additional Documentation Reviewed:

- Photo of drop box in units
- Detainee Request Form to include PREA

Summary

To maintain confidentiality of residents reporting, the facility now has one drop box in each housing unit that residents have access too. This box can be used by residents to report grievances, PREA allegations/reports, and medical requests. This box is checked daily by staff. PREA reports are forwarded immediately to the PREA Coordinator, PREA Compliance Manager, or the Facility Administrator.

The EARJDF is now fully compliant with this 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 facility has a policy entitled “PREA Reporting, Responding, and Data Collection”, that specifies the administrative procedure 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 Youth Handbook contains relevant information to support this standard.

The Facility policy and procedure 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 also requires that a resident grievance alleging sexual abuse not be referred to the staff member who is the subject of the complaint. A review of the Youth Handbook determined that relevant information is provided.

The Facility 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. Facility reports that in the past 12 months:

- (1) There were zero grievances that were filed that alleged sexual abuse;
- (2) There were zero grievances alleging sexual abuse that reached final decision within 90 days after being filed; and
- (3) There were zero grievances alleging sexual abuse that involved extensions because final decision was not reached within 90 days.

Facility policy states that the agency will notify the resident in writing when the agency files for an extension, including notice of the date by which a decision will be made. There are no forms of documentation (grievances alleging sexual abuse, supporting logs that involve an extension) to review.

The policy permits third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and to file such requests on behalf of residents. The policy also require that if the resident declines to have third party assistance in filing a grievance alleging sexual abuse, the agency documents the resident's decision to decline. Policy allows for parents or legal guardians of residents to file a grievance alleging sexual abuse.

The facility has a policy entitled "PREA Reporting, Responding, and Data Collection", that specifies the administrative procedure 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 Youth Handbook contains relevant information to support this standard.

The Facility policy and procedure 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 also requires that a resident grievance alleging sexual abuse not be referred to the staff member who is the subject of the complaint. A review of the Youth Handbook determined that relevant information is provided.

The Facility 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. Facility reports that in the past 12 months:

- (4) There were zero grievances that were filed that alleged sexual abuse;
- (5) There were zero grievances alleging sexual abuse that reached final decision within 90 days after being filed; and
- (6) There were zero grievances alleging sexual abuse that involved extensions because final decision was not reached within 90 days.

Facility policy states that the agency will notify the resident in writing when the agency files for an extension, including notice of the date by which a decision will be made. There are no forms of documentation (grievances alleging sexual abuse, supporting logs that involve an extension) to review.

The policy permits third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and to file such requests on behalf of residents. The policy also require that if the resident declines to have third party assistance in filing a grievance alleging sexual abuse, the agency documents the resident's decision to decline. Policy allows 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 Facility reports that zero grievances alleging sexual abuse filed by residents in the past 12 months in which the resident declined third-party assistance, containing documentation of the resident's decision to decline. There was no documentation of third-party reports and declination of third-party assistance.

Included in the Facility policy are procedures for filing an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. Agency policy contains procedures for emergency grievances alleging substantial risk of imminent sexual abuse that require an initial response within 48 hours. The Facility reports zero emergency grievances alleging substantial risk of imminent sexual abuse were filed in the past 12 months.

The Facility policy includes procedures for emergency grievances alleging substantial risk of imminent sexual abuse require that a final agency decision be issued within 5 days. There is no documentation of emergency grievances filed to review. The policy also addresses limiting its ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith.

The Facility reports that in the past 12 months, zero resident grievances were filed alleging sexual abuse that resulted in disciplinary action by the agency against the resident for having filed the grievance in bad faith. There is no documentation to review of any such disciplinary actions.

Is, on behalf of such resident, regardless of whether or not the resident agrees to having the grievance filed on their behalf.

The Facility reports that zero grievances alleging sexual abuse filed by residents in the past 12 months in which the resident declined third-party assistance, containing documentation of the resident's decision to decline. There was no documentation of third-party reports and declination of third-party assistance.

Included in the Facility policy are procedures for filing an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. Agency policy contains procedures for emergency grievances alleging substantial risk of imminent sexual abuse that require an initial response within 48 hours. The Facility reports zero emergency grievances alleging substantial risk of imminent sexual abuse were filed in the past 12 months.

The Facility policy includes procedures for emergency grievances alleging substantial risk of imminent sexual abuse require that a final agency decision be issued within 5 days. There is no documentation of emergency grievances filed to review. The policy also addresses limiting its ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith.

The Facility reports that in the past 12 months, zero resident grievances were filed alleging sexual abuse that resulted in disciplinary action by the agency against the resident for having filed the grievance in bad faith. There is no documentation to review of any such disciplinary actions.

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.

Facility policy "PREA Reporting, Responding, and Data Collection" provides resident's access to outside victim advocates for emotional support services related to sexual abuse by:

1. Giving residents mailing addresses and telephone numbers of local, State, or national victim advocacy or rape crisis organizations.
2. Giving residents mailing addresses and telephone numbers of immigrant service agencies for persons detained solely for civil immigration purposes.
3. Enabling reasonable communication between residents and these organizations, in as confidential a manner as possible.

Documentation reviewed and observed by auditor consisted of Youth Handbooks, posters hung on walls throughout the facility that includes toll free hotline numbers to crisis counselors and the Department of Child Services, and consular mailing address and phone number. Interviews of residents determined that they are aware of having access to outside victim advocates through phone or written correspondence. The Facility has a memorandum of understanding (MOU) with Mt. Graham Safe House that provides emotional support services related to sexual abuse.

Resident interviews confirmed that the Facility informs residents, prior to giving them access to outside support services, the extent to which such communications will be monitored; and that at time of intake, the Facility informs residents of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant Federal, State, or local law.

The Facility also utilizes contractual services secured by the Arizona Office of the Courts (AOC) to provide counseling services. These contracts were reviewed by the Auditor on the AOC website.

The Facility provides residents with reasonable and confidential access to their attorneys or other legal representation. The Facility also provides residents with reasonable access to parents or legal guardians. Interviews conducted with the PREA Compliance Manager and residents confirm that reasonable access is provided to residents. Visitation is offered four days per week at 30 minute intervals for parents

and guardians. Residents can request to see their attorney at any time.

Facility policy “PREA Reporting, Responding, and Data Collection” provides resident’s access to outside victim advocates for emotional support services related to sexual abuse by:

1. Giving residents mailing addresses and telephone numbers of local, State, or national victim advocacy or rape crisis organizations.
2. Giving residents mailing addresses and telephone numbers of immigrant service agencies for persons detained solely for civil immigration purposes.
3. Enabling reasonable communication between residents and these organizations, in as confidential a manner as possible.

Documentation reviewed and observed by auditor consisted of Youth Handbooks, posters hung on walls throughout the facility that includes toll free hotline numbers to crisis counselors and the Department of Child Services, and consular mailing address and phone number.

Interviews of residents determined that they are aware of having access to outside victim advocates through phone or written correspondence. The Facility has a memorandum of understanding (MOU) with Mt. Graham Safe House that provides emotional support services related to sexual abuse.

Resident interviews confirmed that the Facility informs residents, prior to giving them access to outside support services, the extent to which such communications will be monitored; and that at time of intake, the Facility informs residents of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant Federal, State, or local law.

The Facility also utilizes contractual services secured by the Arizona Office of the Courts (AOC) to provide counseling services. These contracts were reviewed by the Auditor on the AOC website.

The Facility provides residents with reasonable and confidential access to their attorneys or other legal representation. The Facility also provides residents with reasonable access to parents or legal guardians. Interviews conducted with the PREA Compliance Manager and residents confirm that reasonable access is provided to residents. Visitation is offered four days per week at 30 minute intervals for parents and guardians. Residents can request to see their attorney at any time.

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.

Facility policy “PREA Reporting, Responding, and Data Collection” provides a method to receive third-party reports of resident sexual abuse or sexual harassment. The Facility publicly distributes information on how to report resident sexual abuse or sexual harassment on behalf of residents.

The facility has a posting in the lobby informing the public on how to make a third-party report if needed. Third party reports are accepted from fellow youth, staff members, family members, attorneys, and outside advocates. The third-party reporting process is overseen by the PREA Coordinator and Facility Administrator.

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.

Facility policy “PREA Reporting, Responding, and Data Collection” requires all staff to report immediately and according to agency policy:

1. Any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency;
2. Any retaliation against residents or staff who reported such an incident; and
3. Any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

When interviewing with staff, they have a clear understanding of their responsibilities to report immediately. Staff is aware that they are required to comply with any applicable mandatory child abuse reporting laws. This is also included in the Facility’s policy.

Facility policy (mentioned above) prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. In interviews with staff, they acknowledged their understanding of this policy.

During the interviews with medical staff and mental health staff, they had a clear understanding of their duty to report sexual abuse to the Facility Administrator and to the Arizona Department of Child Safety as required by mandatory reporting laws. They also understood the requirement to inform residents at the initiation of services of their duty to report and the limitations of confidentiality. Both the Nurse and Counselor stated that they inform the resident of this upon the resident’s arrival to the facility. Documentation of reports made was verified by the Auditor.

The policy requires the facility head or designee, upon receiving an allegation of sexual abuse, to promptly report the allegation to the appropriate agency office and to the alleged victims’ parents, legal guardians, or if the alleged victim is under the guardianship of the child welfare system, the report shall be made to the alleged victim’s caseworker instead of the parents or legal guardians. The Facility Administrator when interviewed was able to articulate his responsibilities for reporting allegations of sexual abuse.

The policy also states that the facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility’s designated investigators. When in the case of Eastern Arizona Regional Juvenile Detention Facility, the report would be made by facility staff to the Graham County Sheriff’s Office.

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.

Facility policy “PREA Reporting, Responding, and Data Collection” requires when the facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident.

The Facility reports that in the past 12 months, the number of times the facility determined that a resident was subject to substantial risk of imminent sexual abuse was zero. Review of policy and interviews with the PREA Coordinator, Facility Administrator, and random staff demonstrated that protective measures that would be taken in the event it was found that a resident was at imminent risk of sexual abuse.

Standard 115.363 Reporting to other confinement facilities

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

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

The Facility has a policy entitled 'PREA Reporting, Responding, and Data Collection' requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the other facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. The Facility's policy also requires that the head of the facility notify the appropriate investigative agency.

The Facility reports that in the past 12 months, that the facility has received zero allegations that a resident was abused while confined at another facility. Agency policy requires that the facility head provide such notification as soon as possible, but no later than 72 hours after receiving the allegation and that the facility documents that it has provided such notification within 72 hours of receiving the allegation. No other documentation is available for review. Interviews with the Facility Administrator demonstrate a clear understanding of the Facility's responsibility pertaining to this 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.

The Facility has a first responder policy for allegations of sexual abuse. The policy "PREA Reporting, Responding, and Data Collection" section D, requires that upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to:

1. Separate the alleged victim and abuser;
2. Preserve and protect the crime scene;
3. If appropriate, request the alleged victim to not destroy evidence (as detailed in standard); and
4. If appropriate, ensure the alleged abuser does not destroy evidence (as detailed in standard).

A non-security staff first responder is required to request the victim not to destroy evidence (as detailed in standard) and notify a security

staff member.

The Facility reports, that in the last 12 months:

1. Three residents have reported sexual abuse, and of those three allegations, the first security staff member to respond to the report separated the alleged victim and abuser in all three instances;
2. The number of allegations where staff was notified within a time period that still allowed for the collection of physical evidence is three. Of these three incidents, first security staff member to respond to the report preserved and protected any crime scene; requested that the victim not take any actions that could destroy evidence; and ensured that the alleged abuser does not take any actions that could destroy evidence for all three instances; and
3. There were zero allegations made that a resident was sexually abused in which a non-security staff member was the first responder.

Interviews with staff clearly indicate they understand the duties of a first responder. Staff also stated that they receive training on first responder duties annually. The training curriculum first responder duties were reviewed by the Auditor.

Standard 115.365 Coordinated response

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

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

The Facility has developed a detailed, written coordinated response plan which is located in policy entitled “PREA Reporting, Responding, and Data Collection”. The coordinated response plan was developed to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership.

The Facility Administrator stated during interview that staff receives annual training in coordinated response as part of their annual PREA training. This was verified in the review of the training curriculum.

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

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

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

During interview with the Facility Administrator, the Eastern Arizona Regional Juvenile Detention Facility does not have any collective bargaining agreements in place and has not had any at any time. Graham County is a non-union county and therefore has no union collective bargaining agreements.

Standard 115.367 Agency protection against retaliation

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

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

The Facility reports that in the past 12 months there have been zero incidents of retaliation reported, known, or suspected. The Facility policy entitled “PREA Reporting, Responding, and Data Collection” section F, states that retaliation against any client or staff member that reports sexual abuse or participates in an investigation is not tolerated. There have been no allegations of sexual abuse or sexual harassment from currently detained residents so the Auditor could not interview any alleged victims.

The agency reports that the designated staff member charged with monitoring retaliation is the PREA Coordinator, Eric Gore. Interviews with the Facility Administrator and PREA Coordinator indicate the requirements of this standard would be met in the event the agency does gain knowledge, suspicion, or an actual allegation of retaliation.

Standard 115.368 Post-allegation protective custody

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

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

The Facility’s practice is not to use segregated housing. During the tour of the facility, the Auditor observed that the facility is designed in such a way that single rooms or alternative housing units can be utilized. Facility policy entitled “PREA Reporting, Responding, and Data Collection” states that the perpetrator or victim will not be held in isolation under any circumstance.

Facility reports that in the past 12 months they have has zero residents who allege to have suffered sexual abuse who were placed in isolation. Interviews with random staff, medical staff, and mental health staff confirm that no residents have been held in segregated housing.

Standard 115.371 Criminal and administrative agency investigations

- Exceeds Standard (substantially exceeds requirement of standard)

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

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

The PREA Coordinator and Facility Administrator state that the facility refers all allegations of sexual abuse to the Graham County Sheriff's Office (GCSO). The agency reported that in the last 12 months there have been no allegations of conduct that appear to be criminal and no criminal investigations. The agency's policy entitled "PREA Responsive Planning" governs the conduct of administrative investigations.

The facility will, by policy, retain all written reports pertaining to such investigations for as long as the alleged abuser is incarcerated or employed by the agency, plus five years, unless the abuse was committed by a resident and applicable law requires a shorter record of retention. Policy also states that the Facility will request documentation from the GCSO of any relevant investigation information in order to inform the resident as to the outcome of the investigation. Prior year's documentation was reviewed by the Auditor to ensure record retention is being maintained per the standard.

The PREA Coordinator stated that the Facility cooperates with GCSO and shall endeavor to remain informed about the progress of the investigation.

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.

Facility policy entitled "PREA Responsive Planning" states that the agency shall impose a standard of a preponderance of the evidence or a lower standard of proof when determining whether allegations of sexual abuse or sexual harassment are substantiated. The Graham County Sheriff's Office, as the investigative agency will determine the preponderance of evidence in determining whether allegations are substantiated. Interviews with investigative staff confirm compliance with this 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.

The Facility reports that there have been zero criminal and/or administrative investigations of alleged youth sexual abuse that were completed in the last 12 months. Because there have been neither allegations nor investigations, the auditor was unable to review any notification documentation for this standard.

The Facility policy entitled "PREA Responsive Planning" requires that any resident who makes an allegation that he or she suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency. Policy also states that the Facility requests the relevant information from the investigating entity, Graham County Sheriff's Office, in order to inform the resident of the outcome of the investigation. Policy requires that all notifications to residents under this standard are documented. Interviews with the Facility Administrator and PREA Coordinator confirm this practice that demonstrates compliance.

Following a resident's allegation that a staff member has committed sexual abuse against a resident, the Facility subsequently informs the resident whenever:

1. The staff member is no longer posted within the resident's unit;
2. The staff member is no longer employed at the facility;
3. The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or
4. The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

Standard 115.376 Disciplinary sanctions for staff

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

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

The Facility reports that in the last 12 months there has been zero staff from the facility that have been terminated, or resigned before they were terminated, for violating agency sexual abuse or sexual harassment policies. Additionally, there has been zero staff in the past months that have been disciplined for violations of the agency sexual abuse or sexual harassment policies. There has been zero staff that has been reported to law enforcement or licensing boards for violating agency policies within the last 12 months.

The Facility's disciplinary policy requires that staff be subject to disciplinary action up to and including termination of employment for violations of sexual abuse, harassment, or sexual misconduct.

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.

The Facility reports that there have been zero contactor/volunteers reported to law enforcement or relevant licensing bodies in the past 12 months for engaging in sexual abuse of youth. The Facility's policy requires that any contactor or volunteer who engages in sexual abuse be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.

Interview with Facility Administrator indicate that the practice of the facility conforms to this standard. According to the Facility Administrator, Charles Gatwood, the Facility would take appropriate remedial measures and would consider whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

Standard 115.378 Disciplinary sanctions for residents

- Exceeds Standard (substantially exceeds requirement of standard)
- X 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 reports that in the past 12 months there have been zero administrative findings and zero criminal findings of guilt for resident-on-resident sexual abuse that have occurred at the facility.

The facility does not have a policy that addresses this standard. No disciplinary process or sanctions were supported by documentation. Whether sanctions are too commensurate with the nature and circumstances of the abuse committed, youth disciplinary history and comparable offense sanctions cannot be properly evaluated due to lack of documentation or detailed disciplinary process and policy. This is also the case for the disciplinary process considering whether the resident's mental disability or illness contributed to his or her behavior when determining sanctions.

Interviews indicate that the facility does not use isolation as a disciplinary sanction however this is not supported by policy or documentation. In the pre-audit questionnaire completed by the agency, three cells are classified as segregation (administrative and disciplinary) type cells.

There is no policy or supporting documentation stating whether or not the facility offers any therapy, counseling, or other interventions as a part of an overall disciplinary process. There is also no policy or documentation regarding the discipline of a resident for sexual contact with a staff member upon finding that the staff member did not consent to such contact.

Through interviews with the PREA Coordinator and the Facility Administrator, it was determined that the Facility does prohibit sexual activity between resident and may discipline for such activity, however this is not represented in policy or any supporting documentation.

CORRECTIVE ACTION NEEDED:

1. The facility shall develop a policy to address standard 115.378 to include subsections (a) through (g).

VERIFICATION OF CORRECTIVE ACTION SINCE THE AUDIT

The Auditor was provided supplemental documentation on October 20, 2016 to evidence and demonstrate corrective actions taken by the EARJDF administration regarding this standard. This documentation is discussed below.

Additional Documentation Reviewed:

Policy “PREA Discipline”

Summary

The facility developed a policy “PREA Discipline” to address 115.378 subsections a through g, that addresses staff disciplinary sanctions, corrective action for contractors and volunteers, and interventions and disciplinary sanctions for residents.

The EARJDF is now fully compliant with this 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.

Facility policy entitled “PREA Screening for Risk of Sexual Victimization and Abusiveness”, along with staff interviews support that if a resident reports prior sexual victimization, whether it occurred in an institutional setting or in the community, Department of Child Safety will be contacted immediately, and that staff shall ensure the resident is offered follow-up services with mental health practitioners within 14 days. Residents who have perpetrated sexual abuse according to facility policy will be referred to the detention counselor.

The Facility reported that in the past 12 months, six residents have disclosed prior victimization during screening was provided a follow-up meeting with the Detention Counselor.

According to facility policy, any information related to sexual victimization or abusiveness shall be strictly limited to appropriate staff as needed in order to make informed decisions regarding housing, program assignments, etc.

Ample documentation was provided to support this standard. The facility utilizes multiple means of documentation and tracking, to include incident reports and log book notations.

Medical and mental health staff reported that their records are kept in a secure area but separate from the resident’s other records.

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.

Staff interviews demonstrate that victims of sexual assault receive emergency treatment in a timely manner. Interviews with first responders and agency policy entitled “PREA Reporting, Responding, and Data Collection”, Section D, demonstrates that staff first responders shall take preliminary steps to protect the victim pursuant to 115.362 and shall immediately notify the appropriate medical and mental health practitioners.

Policy 03-17.4 “Health and Medical Services “and interviews with facility medical practitioner confirm that resident victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care where medically appropriate. Policy also states that treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

Documentation was provided in form of an STD flyer that residents receive at time of intake.

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

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

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

The facility does not have a policy or documentation in place to address 115.383 a-h:

115.383 (a) The facility shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.

115.383 (b) The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.

115.383 (c) The facility shall provide such victims with medical and mental health services consistent with the community level of care.

115.383 (d) Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests.

115.383 (e) If pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services.

115.383 (f) Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate.

115.383 (g) Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

115.383 (h) The facility shall attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners.

Interviews with the Detention Counselor and PREA Coordinator indicate that the facility offers medical and mental health evaluations and treatment to all residents who are victimized by sexual abuse. There were no residents detained during time of audit who reported a sexual abuse that could be interviewed.

CORRECTIVE ACTION NEEDED:

1. The Facility shall develop a policy and procedures to cover standard 115.383, including all subsections (a) through (h).

VERIFICATION OF CORRECTIVE ACTION SINCE THE AUDIT

The Auditor was provided supplemental documentation on October 20, 2016 to evidence and demonstrate corrective actions taken by the EARJDF administration regarding this standard. This documentation is discussed below.

Additional Documentation Reviewed:

Policy “Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers”

Summary

The facility developed a new policy “Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers” that addresses the following:

115.383 (a) The facility shall offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.

115.383 (b) The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.

115.383 (c) The facility shall provide such victims with medical and mental health services consistent with the community level of care.

115.383 (d) Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests.

115.383 (e) If pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services.

115.383 (f) Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate.

115.383 (g) Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

115.383 (h) The facility shall attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners.

The EARJDF is now fully compliant with this 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.

The Facility reported that in the past 12 months there have been zero criminal and/or administrative investigations of alleged sexual abuse completed at the facility, excluding only “unfounded” incidents. The Facility has developed a Sexual Abuse Review Team (SART) for the review of all sexual abuse investigations. Documentation of a completed SART checklist was provided to the Auditor for verification. The form conforms to standard 115.386 subsections (d) (1) through (6).

Facility policy entitled “PREA Reporting, Responding, and Data Collection”, requires that these reviews will occur within 30 days of the

conclusion of the investigation. The review team consists of upper level management officials, with input from line supervisors, investigators, and medical or mental health practitioners. The review team will consider, examine, and assess all data relevant to PREA standard 115.386(d) and prepare a report on the findings. The report containing the team findings and recommendations will be provided to the detention Administrator or designee. The facility will implement the recommendations for improvement, and shall document its reasons for not doing so.

It is recommended that the Facility expand the review team to include all staff that may have been involved with each step of the process, to include line staff and first responders and the SART should contain all signatures of those that participated.

Interviews with the PREA Coordinator and the PREA Compliance Manager indicate the formal incident review process is developed in policy and practice and fulfills all the specified requirements.

Standard 115.387 Data collection

- Exceeds Standard (substantially exceeds requirement of standard)
- x 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 entitled “PREA Reporting, Responding, and Data Collection” all relevant data will be collected for incidents of sexual abuse within the facility. The facility provided documentation to verify an annual PREA review had been conducted. The information collected is consistent with the PREA standards and using the Department of Justice annual Survey of Sexual Violence (SSV) as a minimum guideline.

The annual data report was provided and reviewed by the auditor. The Facility collects accurate, uniform data for every allegation of sexual abuse and uses a standardized instrument and set of definitions. The Facility aggregates the data annually and prepares a report. The Facility’s PREA Coordinator and Facility Administrator, through interview, are responsible for gathering and analyzing the data, and preparing the written report.

Standard 115.388 Data review for corrective action

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

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

The Facility reviews data collected and aggregated pursuant to 115.387 in order to assess and improve the effectiveness of its sexual prevention, detection, and response policies, practices, and training, including:

1. Identifying problem areas;
2. Taking corrective action on an ongoing basis; and
3. Preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the agency as a whole. Interviews with the PREA Coordinator and the Facility Administrator reports that data is collected annually.

The Facility has not made the annual report readily available to the public through its website, or other means.

CORRECTIVE ACTION NEEDED:

1. The Facility shall publish the Annual PREA Report to agency’s website each year. This can be verified by reviewing the agency’s website.

VERIFICATION OF CORRECTIVE ACTION SINCE THE AUDIT

The Auditor was provided supplemental documentation on October 20, 2016 to evidence and demonstrate corrective actions taken by the EARJDF administration regarding this standard. This documentation is discussed below.

Additional Documentation Reviewed:

www.graham.az.gov/wp-content/uploads/2016PREAAnnualReport.pdf

Summary

The Auditor was able to verify on the agency’s website the 2016 PREA Annual Report for EARJDF. The annual report contains data review for corrective action, 2015-16 corrective action items, and recommendations. The annual report also contains noncompliance issues from the interim audit report.

The EARJDF is now fully compliant with this 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.

Through interview with the Facility Administrator, all facility incident-based and aggregate data that is collected is securely retained by the Facility Administrator. The facility makes this data available on its website. This was verified by the Auditor. According to interview with the PREA Coordinator, all personal identifiers are removed. This was verified by the auditor during a check of the document that was located on the website. The collected sexual abuse data is retained for at least 10 years after the date of initial collection and in accordance with the state record retention schedule.

The standard is supported by Facility policy entitled “PREA Reporting, Responding, and Data Collection”.

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

- x 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 Brideschge *Elaine Brideschge*

October 28, 2016

Auditor Signature

Date