

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

**Date of report:** June 7, 2016

<b>Auditor Information</b>			
<b>Auditor name:</b> Louis A. Goodman			
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<b>Date of facility visit:</b> December 10-11, 2015			
<b>Facility Information</b>			
<b>Facility name:</b> Santa Cruz County Juvenile Detention Center			
<b>Facility physical address:</b> 2170 N. Congress Drive, Nogales, AZ 85621			
<b>Facility mailing address:</b> <i>(if different from above)</i>			
<b>Facility telephone number:</b> (520) 375-8195			
<b>The facility is:</b>	<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		
<b>Facility type:</b>	<input type="checkbox"/> Correctional	<input checked="" type="checkbox"/> Detention	<input type="checkbox"/> Other
<b>Name of facility's Chief Executive Officer:</b> Omar Villa (at the time of the site visit); Alicia Valenzuela			
<b>Number of staff assigned to the facility in the last 12 months:</b> 1			
<b>Designed facility capacity:</b> 32			
<b>Current population of facility:</b> 5			
<b>Facility security levels/inmate custody levels:</b> Secure			
<b>Age range of the population:</b> 13-17			
<b>Name of PREA Compliance Manager:</b> NA		<b>Title:</b>	
<b>Email address:</b>		<b>Telephone number:</b>	
<b>Agency Information</b>			
<b>Name of agency:</b> Santa Cruz County Probation Department			
<b>Governing authority or parent agency:</b> <i>(if applicable)</i>			
<b>Physical address:</b> 2160 N. Congress Drive, Nogales, AZ 85621			
<b>Mailing address:</b> <i>(if different from above)</i>			
<b>Telephone number:</b> (520) 375-7640			
<b>Agency Chief Executive Officer</b>			
<b>Name:</b> Primitivo Romero III		<b>Title:</b> Chief Probation Officer	
<b>Email address:</b> promero@courts.az.gov		<b>Telephone number:</b> (520) 375-7640	
<b>Agency-Wide PREA Coordinator</b>			
<b>Name:</b> Luis B. Fimbres		<b>Title:</b> Chief Deputy Probation Officer	
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*Revised 06/08/16 bds*

## **AUDIT FINDINGS**

### **NARRATIVE**

The Santa Cruz County Probation Department contracted with Goodman Consulting, LLC, to audit The Santa Cruz County Juvenile Detention Center (SCCJDC or "the facility"), a secure detention center operated by the Juvenile Detention Services Division (JDSD) in Nogales, Arizona. Louis A. Goodman, an auditor accredited by the United States Department of Justice, conducted the audit, including a site visit on December 10 and 11, 2015.

The auditor provided an announcement of the upcoming audit to the facility on October 24, 2015, and the notice was posted at SCCJDC more than six weeks prior to the site visit, as verified by photographs provided the auditor. On November 18, 2015, the auditor received the facility's completed Pre-Audit Questionnaire, agency policies, and other documents. Additional documents were forwarded to the auditor on November 23, 2015. Prior to the site visit, the auditor comprehensively reviewed all of the materials the facility provided, including the responses to the Pre-Audit Questionnaire.

At the outset of the site visit, the auditor held an informational meeting with the Chief Probation Officer, the Chief Deputy Probation Officer/PREA Coordinator, the Detention Supervisor ("superintendent" of the facility,) who has since retired, and his successor. The meeting was followed by an extensive tour of the facility, during which the auditor was given access to all areas of the facility, including the unlocking and opening of all doors as requested. The tour also included the outdoor recreation areas. Residents of the facility were in school on the premises at the time of the tour, and the auditor was able to observe classes in progress.

Over the course of the two-day audit, the auditor conducted interviews of administrators, staff, contractors, a volunteer, and residents. All interviews were conducted in accordance with the protocols established by the DOJ. There were a total of 17 interviews, which covered all of the positions and roles required by the DOJ protocols. Due to the facility's small size, staff as well as administrators perform multiple functions, including intake, screening, first responder duties, and membership on the incident review team. Five residents were interviewed. The residents were selected at random from a roster the facility provided during the site visit. Three of the residents were Spanish-speaking, and the interviews were conducted with the assistance of a Santa Cruz County Court Interpreter. There were no residents who fell into the other special categories set out in the audit protocols. No residents were in isolation, there were none who identified as lesbian, gay, bisexual, transgender, or intersex, and there were no reports of sexual abuse or harassment made in the past 12 months. The auditor also conducted interviews of four detention officers, who were selected at random as well as possible, given the small population of the facility and the correspondingly small number of line staff on duty.

During the site visit the auditor randomly selected five staff personnel files to review for background check documentation and signature sheets reflecting PREA training and an understanding of the material presented in them. The facility also provided the auditor considerable additional documentation during and after the site visit.

At the conclusion of the site visit, the auditor held a debriefing attended by the Chief Probation Officer, the Deputy Chief Probation Officer/PREA Coordinator, and the Detention Supervisor. During that meeting the auditor reported preliminary findings, including both strengths and weaknesses observed over the course of the visit.

Throughout the audit process, the administrators and staff of the JDSD were extremely professional and cooperative.

## **DESCRIPTION OF FACILITY CHARACTERISTICS**

The mission statement of the Santa Cruz County Probation Department is "to serve and protect the public, restore victims, supervise offenders while adhering to evidence based practices, hold offenders accountable for their behavior, while offering services designed to assist offenders overcome whatever adverse circumstances they may be facing." The Probation Department's stated values are: Excellence, Integrity, Professionalism, Accountability, and Compassion.

The SCCJDC houses both male and female pre-adjudication youth from Santa Cruz County, a small county in southern Arizona on the Mexican border. It reports an average length of stay of 16.1 days. The facility, which opened in 2011, consists of three housing pods, one of which is not in use due to a decline in population. There are 32 total beds in the facility, 16 of which are in operation. At the outset of the site visit on December 10, 2015, the population of the facility was five youth. There were four admissions during the site visit, raising the population to nine. Only one of the residents was female. She was housed in her own housing unit.

The facility consists of a single building and three outdoor recreation areas. It contains a single control room, two classrooms, individual visitation rooms, a non-contact meeting room, and an indoor recreation room. There is an intake area and a medical unit. There are three living units, each of which has cells on two tiers. The smallest of the of the three living units was not occupied at the time of the visit and is being used for storage. Residents are single bunked, and each room contains a toilet and sink. There is one isolation cell on each of the living units. Currently, the rooms on the upper tiers in the two occupied units are not in use.

The residents' rooms in each living unit are lined up along one wall and open to a day area with a desk at which an officer is posted. There are fixed tables and chairs in the day area, where the residents eat their meals. Two single showers are located on the side of each unit opposite the residents' rooms. Each housing unit opens to its own recreation yard.

The facility was designed to minimize blind spots and in addition has an extensive network of 63 cameras, which are monitored in the control room. Small blind spots in the living areas are marked off by red lines and are off-limits to residents. Each of the outdoor recreation areas has two cameras.

The Santa Cruz County Education Superintendent's Office provides accredited education at the facility. Residents who stay for longer periods can earn credits toward graduation that transfer to public high schools. In addition to education, the facility provides group counseling, recreation, and religious services. It utilizes a level system whereby residents earn or lose privileges based upon their behavior.

## **SUMMARY OF AUDIT FINDINGS**

The Interim Audit Report was issued on January 11, 2016 and included 28 findings of "standard met," 10 findings of "standard not met," and 3 findings of "standard not applicable." For each standard not met, the interim report provided specific corrective actions to be taken by the facility. The facility submitted a Corrective Action Plan to the auditor on February 11, 2016. During the corrective action period the facility remained in communication with the auditor and provided information and documentation on three occasions to demonstrate progress on the Corrective Action Plan. All of the required corrective actions were addressed successfully by May 3, 2016.

Overall, the auditor observed an immaculate, well run facility, where the implementation of PREA is clearly a priority and is reflected in the agency culture. Each of the residents I interviewed reported feeling safe in the facility. The administrators and detention officers with whom I spoke reflected a youth-centered organization where the wellbeing of residents is their paramount concern. Administrators were open to the auditor's suggestions and advice and demonstrated their determination to comply with the PREA standards.

Number of standards exceeded: 0

Number of standards met: 38

Number of standards not met: 0

Number of standards not applicable: 3

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

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

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

The Juvenile Detention Services Division (JDSD) has enacted a comprehensive PREA compliance policy, Policy III A 20, which contains zero tolerance language regarding sexual abuse and sexual harassment at § III A 20.1. Policy III A 20 incorporates virtually all of the PREA requirements for juvenile facilities and thus lays out the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. It clearly states a policy of zero tolerance and contains the definitions of prohibited behaviors.

The agency has designated a PREA Coordinator, the Chief Deputy Probation Officer. As the agency's second in command, he reports directly to the Chief Probation Officer, agency CEO, and states that he has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards.

The agency has only one facility and therefore is not required to have a PREA compliance manager.

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

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

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

NA. The agency does not contract with other entities for the confinement of residents.

**Standard 115.313 Supervision and monitoring**

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

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The facility staffing plan is post-based, rather than ratio-based and has been in effect throughout the past 12 months. SCCJDC posts 4 officers on the morning and swing shifts and 3 officers on the night shift. Those officers cover the 2 occupied units, neither of which is authorized for more than eight youth. The total average daily population of the facility is 8.1. Thus, the effective staffing ratios are well below the 1:8 and 1:16 ratios that will be effective, beginning October 1, 2017. In the event of an officer's absence, staff coverage is provided using overtime or by the intermediate supervisor or an administrator. In addition to direct care staff, the facility has 63 cameras located throughout. Select cameras are monitored in the control room, and the video produced by all of the cameras is recorded.

The facility has a written staffing plan, although it was not created until November 16, 2015. It reflects the staffing model and the use of cameras described above. It also reflects participation of the Chief Probation Officer, Chief Deputy Probation Officer/PREA Coordinator, and the Juvenile Detention Supervisor at a meeting at which the 11 factors enumerated in paragraph (a) of this standard were considered. Having only recently adopted a written staffing plan, the facility has not had an opportunity for annual review.

The facility reports that it has not deviated from its staffing plan in the past 12 months, and thus it has no document reflecting deviation. In fact, it has developed no document for that purpose. In order to review staffing, it is necessary to view daily reports. The agency has provided a form that will track shift-by-shift staffing numbers, which will not only provide a mechanism for easy review of this standard, but will allow for recording an explanation in the event of deviation from the plan. Use of the form should be implemented.

Facility Policy III A 20.6 provides for unannounced rounds by supervisors or administrators on all shifts, and it prohibits staff from alerting other staff members that unannounced rounds are taking place. The facility provided documentation of the rounds.

### **Standard 115.315 Limits to cross-gender viewing and searches**

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

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

The facility prohibits cross-gender strip searches and cross-gender body cavity searches. (Policy III A 20.7). The same policy provision prohibits cross-gender pat searches, and all of the residents and staff interviewed reported that such searches do not occur.

Facility procedure and practices ensure that residents are able to shower and change clothing without being viewed by opposite-gender staff. The housing units have individual showers with opaque doors. Residents use the showers to change clothes. There is a toilet in each resident's room, and their doors have windows that allow a view of the resident from a certain angle. In order to assure privacy, the facility has developed a practice whereby a resident using the toilet turns off the light, leaving only a far dimmer "safety light" on in the room. This alerts staff that the resident is using the toilet and the dimmer light makes it more difficult to see the resident. It is noteworthy that all of the residents I interviewed expressed confidence that this practice works and that opposite gender viewing does not occur. However, at the time of the site visit, the opposite gender facility staff did not announce their presence when entering a housing area, as required by paragraph (d) of this standard, and facility policy did not require such announcements.

Facility policy prohibits searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. However, at the time of the site visit, the facility had not trained staff in how to conduct searches of transgender or intersex residents professionally and respectfully, nor had it trained staff how to conduct cross-gender pat searches, in the event of exigent circumstances, as paragraph (f) of this standard requires.

During the corrective action period, the facility successfully addressed the deficiencies noted. Policy III A 20.7 was amended, effective February 5, 2016 to require that opposite sex staff announce their presence when entering a housing area, and staff now adhere to that policy. In addition, all staff were required to view a National PREA Resource Center training video on cross-gender searches and searches of transgender and intersex residents. The facility provided training documents reflecting that all staff members completed the training in January, 2016 and signed a document attesting to having understood the material.

### **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.**

Situated just a few miles from the Mexican border, the facility does an outstanding job of providing services to Spanish speaking residents. Not only are the written PREA materials for juveniles available in Spanish, but all staff members are bilingual. As a result, intake, PREA education, and all other programming is conducted in Spanish whenever necessary, and interpreters are unnecessary unless an outside contract provider does not speak Spanish. Under no circumstances do residents act as interpreters for other residents. Three of the residents I interviewed during the site visit were monolingual Spanish speakers. For those interviews, the facility provided a court interpreter, rather than having a staff member be present to interpret. The facility has received no residents who speak neither English nor Spanish in the experience of any of the administrators with whom I spoke, but the facility has access to a Santa Cruz County Superior Court contract for telephonic interpreting, should those circumstances arise.

Facility policy requires the provision of PREA education in formats accessible to all residents, including those who are disabled or have limited reading ability. (Pol. III A 20.9) For deaf or hard of hearing residents, the facility has an agreement with an outside provider for sign language interpreting. For other types of disabilities, administrators report that they would rely upon personally working with any resident who needed additional attention or explanation of PREA-related issues, as well as use teachers and behavioral health providers where appropriate. There were no residents with disabilities in the facility at the time of my site visit.

#### **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)

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Agency policy explicitly prohibits hiring or promoting any person who may have contact with residents or enlisting the services of any contractor who may have contact with residents who fall within any of the categories set out in paragraph (a) of this Standard. It also requires the consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to engage a contractor who may have contact with residents. (III A 20.6)

The facility performs a criminal background check before hiring new employees who may have contact with residents and 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 sexual abuse. Similar checks are conducted before enlisting the services of a contractor who may have contact with residents. Additional criminal background checks are conducted for employees every two years, surpassing the five-year requirement of this standard. During the site visit I reviewed five employee personnel files, which I selected randomly. All contained the required criminal background checks, including the follow-up checks done every two years. However, at the time of the site visit, the facility did not consult child abuse registries prior to hiring an employee or engaging a contractor who may have contact with youth, as required by paragraphs (c) and (d) of this standard.

On January 21, 2016, the facility initiated the process of consulting Arizona's child abuse registry by conducting checks on all current employees and volunteers, all of whom were cleared, as reflected in documentation the facility provided for review. Since that date, the facility has included consulting that registry as part of the recruiting process for all prospective employees and volunteers.

Policy III A 20.6 requires that agencies ask persons applying for employment or promotion the questions set out in paragraph (a) of this standard, either in a written application or in an interview. However, at the time of the site visit, this requirement had not been incorporated into practice. The facility has subsequently added those questions to its interview format and reports incorporating the change into practice. Facility policy also imposes upon

employees a continuing affirmative duty to disclose any such misconduct and that material omissions regarding such misconduct, or providing materially false information, is grounds for termination.

Finally, paragraph (h) of this Standard requires that, unless prohibited by law, the agency shall provide information on substantiated allegation of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work. At the time of the site visit, agency policy (III A 20.6, p. 17) stated that making such a disclosure to a potential institutional employer requires "a signed authorization for release of information." This qualifying statement defeated the purpose of the requirement in paragraph (h), as such former employees are unlikely to give consent. During the corrective action period, the facility amended the policy, effective January 29, 2016, to delete the signed authorization and release requirement for reporting to an inquiring potential institutional employer that a former employee had a substantiated allegation of sexual abuse or sexual harassment.

### **Standard 115.318 Upgrades to facilities and technologies**

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

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NA This facility opened in 2011 and has not been expanded or modified since August 20, 2012. Neither has the video monitoring system been updated since then.

### **Standard 115.321 Evidence protocol and forensic medical examinations**

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

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The facility did not have any incidents or allegations of sexual abuse during the past 12 months.

The Nogales Police Department is responsible for conducting criminal investigations into allegations of sexual abuse at the facility. Administrative investigations are conducted by Deputy Chief Probation Officer, but the agency does not conduct forensic medical examinations. The agency reports that it uses a uniform evidence protocol for the administrative investigations.

Although there is no SAFE or SANE available locally, any resident who experienced sexual assault would be transported to a local hospital. Either a medical examination would be performed at the local hospital, or the resident would be transported from the local hospital to a hospital in Tucson, about 60 miles away, where a a SAFE or SANE would be available. There would be no charge for the examination.

There is no dedicated rape crisis agency in Santa Cruz County, but the agency has a relationship with the Regional Behavioral Health Agency (RHBA) designated to serve the county. Through the RBHA, an agency called Nursewise provides crisis services and would provide victim advocacy services through a qualified staff member in the event of a sexual assault. As requested by the victim, the qualified service provider would accompany and support the victim through the forensic examination process and investigatory interviews and would provide emotional support, crisis intervention, information, and referrals.

The agency states that it has requested that the Nogales Police Department, which would conduct the criminal investigation of a sexual assault, follow the requirements of paragraphs (a) through (e) of this standard. The Nogales Police Department responded that when it conducts investigations of sexual abuse, it uses the protocol taught all Arizona law enforcement officers certified by Arizona Peace Officer Standards and Training Council (AZPOST) and the United States Department of Justice.

#### **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.**

Although the facility had no incidents or allegations of sexual assault during the past 12 months to review, its policy clearly provides for the investigation of all such allegations. Allegation of sexual abuse or sexual harassment must be reported to local law enforcement, the Nogales Police Department (NPD), unless the allegation does not involve potentially criminal behavior. The policy describes the responsibilities of both the agency and the NPD and is published on the agency website. (Pol. III A 20.12)

#### **Standard 115.331 Employee training**

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

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The facility provides comprehensive training on PREA. I reviewed the training curriculum and found it to cover all of the topics required by paragraphs (a) and (b) of this standard. Policy requires that training be delivered to every employee annually. (III A 20.8) During interviews, all of the administrators and staff with whom I spoke reported having received the PREA training and were able to discuss the various elements. Prior to the on-site audit, the facility provided "sign-in sheets" reflecting that employees attended the training, but no documentation that employees completed and understood the training, as required in paragraph (d) of this standard, was provided. During the corrective action period, the facility rectified this deficiency by adopting a form to be completed at the end of training, reflecting that each signatory completed and understood the training. The facility provided a signed copy of that form for each employee attesting to completion and understanding of agency PREA training.

#### **Standard 115.332 Volunteer and contractor training**

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

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JDSD policy requires that all volunteers and contractors who may have contact with residents receive the training required by this Standard. Sign-in sheets and interviews of one volunteer and three contract personnel confirmed that the training is being delivered. However, at the time of the site visit, the agency did not maintain documentation confirming that the volunteers and contractors completed and understood the training they have received, as mandated by paragraph (c) of this Standard. During the corrective action period, the facility obtained and provided the auditor signed forms from each of its contractors and volunteers confirming that the signatories have completed and understood the PREA training the agency provided them.

### **Standard 115.333 Resident education**

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

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The site visit included interviews of four of the five residents present at the facility when the auditor arrived and one of the residents admitted during the site visit. All confirmed that they were presented information on PREA at arrival. Each was given a brochure covering the topics set out in paragraph (a) of this standard. Spanish speaking residents received a Spanish language version of the brochure. Due to the small size of the facility and the infrequency of intake, there is no dedicated intake staff. Rather, intake can be handled by any of the detention officers. Interviews of the residents revealed some inconsistency in intake practices; some of the residents stated that the intake officer explained what was in the brochure, and others stated that they were simply handed the brochure and told to read it. It is recommended that the facility address this by providing additional training to detention officers emphasizing the need to discuss the PREA brochure with residents when distributing it. This is especially important in the case of residents with limited reading skills.

Within 10 days of intake, a facility administrator meets with each resident to provide comprehensive age-appropriate education covering the topics required by paragraph (b) of this Standard. The administrators are bilingual and able to deliver the education in Spanish, as well as English. Additionally, because delivery can be individualized for each resident, modification is made for residents who have limited reading skills or disabilities. As addressed above, the facility has access to sign language interpreters and interpreters for languages other than Spanish, should the need arise. The facility produced signature sheets that document residents' participation in these training sessions.

During the facility tour, the auditor observed posters throughout the facility, some in English and some in Spanish, that addressed the issues of sexual assault and sexual harassment and provided information for reporting incidents.

### **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)

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

The agency is responsible for all administrative investigations, including investigations of alleged sexual abuse. In practice, the outcome of administrative allegations of sexual abuse would await and typically be determined by the outcome of a criminal investigation conducted by the local police department. However, administrative investigations have a lower burden of proof than criminal investigations, making it possible that an allegation be unsubstantiated in the criminal investigation, but substantiated in the administrative investigation. In any event, this standard explicitly requires specialized training for investigators who conduct administrative investigations. The investigator who conducts those investigations at the facility had not received that training at the time of the site visit.

During the corrective action period, the facility's investigator completed ten online courses offered by the PREA Learning Center of the National Institute of Corrections, including "PREA: Investigating Sexual Abuse in a Confinement Setting." Based on the documentation provided the auditor, including a memorandum from the investigator, a training transcript, and certificates of completion, all courses were completed by April 5, 2016, satisfying the requirements of this Standard.

#### **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)

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Policy III A 20.8 requires that medical and mental health staff receive the training described in paragraph (a) of this standard. Interviews of medical and mental health providers confirmed that they had in fact received such training, and the agency produced documentation. The providers also received the general PREA training for employees or contractors, as appropriate. Agency medical staff do not conduct forensic examinations.

#### **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.**

Agency policy requires the screening of all residents within 72 hours of arrival, in accordance with this Standard. (Pol. III A 20.6) However, at the time of the site visit, the facility was not using an objective screening instrument, nor was it applying the criteria set out in paragraph 115.341(c). Intake consisted of conversation with the resident and a review of file information, if available. During the site visit, the facility provided a draft of an instrument designed to incorporate the 11 elements required in paragraph (c) of this standard, but it had not been finalized and implemented.

During the corrective action period, the facility revised and implemented its screening instrument. Staff training was completed on February 16, 2016, as demonstrated by a curriculum and sheets bearing the signatures of staff members and attesting to their completion and understanding of the material. The screening instrument designed by the facility contains all 11 of the elements required by this standard. The training curriculum and a review process is designed to ensure consistency among staff who complete the screening instruments. The training also covered the sensitivity of the information gathered

during the screening process and restrictions on its communication, although the small size of the facility is such that it is necessary for all of the youth contact staff generally to be privy to information regarding each resident for the safety and wellbeing of residents and staff.

### 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.**

Although the JDSD was not using the screening instrument required by Standard 115.341 at the time of the site visit, staff at the facility nonetheless screened residents at intake and used the information obtained to make housing, bed, program and education assignments. As a practical matter, the small size of the facility means that all male residents are typically held in a single unit, but more vulnerable or aggressive residents are placed in rooms closer to the staff work station. The second operational housing unit is available for female residents. As described in above, the facility has now begun to administer an appropriate screening instrument. The newly developed objective screening tool is now used to facilitate housing, bed, program and education assignments.

Isolation is used only as a last resort and when less restrictive measures are inadequate to keep residents safe. When isolated, residents receive daily visits from a medical or mental health care clinician. Administrators reported that typically, a resident being housed in an isolation cell participates in regular programming to the extent possible. Residents typically remain in isolation for a matter of hours to two or three days when they pose an imminent danger to self. Isolation cells are used because they allow for observation of residents believed to be imminent dangers to self or others. Thus, "isolation" in the facility does not equate to isolation in the true sense, it merely means that when residents are in their rooms, the "isolated" resident is in a room on the unit that enables increased observation. When a resident is isolated, the facility documents the basis for the concern for the resident's safety and the reason why no less restrictive measures could be taken. There were no residents in isolation during of the site visit.

Lesbian, gay bisexual, transgender or intersex (LGBTI) youth are not placed in particular housing or bed assignments solely on the basis of their LGBTI status, nor is that status considered an indicator of likelihood of being sexually abusive. There were no LGBTI-identified residents in the facility at the time of the site visit. Administrators and staff reported not having housed any residents known to be transgender or intersex, but agency policy is consistent with all of the housing and programming assignment provisions in this standard. (Pol. III A 20.10)

### Standard 115.351 Resident reporting

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

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

The facility provides multiple ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for making such reports, and staff neglect or violation of responsibilities that may have contributed to any incidents. Residents may make written reports through the grievance system, using one of the locked grievance boxes located throughout the facility. Written reports can also be given directly to staff or administrators, and reports can likewise be made orally. Residents have access to writing materials when they wish to make a written report. Reports can also be made via third parties, such as parents/guardians, caseworkers, and attorneys. All of the residents I interviewed expressed awareness of these reporting methods. Staff expressed an understanding that they are required to accept reports made using any format or method, including anonymous

reports and reports from third parties, and they are required to document reports made verbally.

Residents also have access to a hotline operated by Nursewise, a private agency with whom the facility contracts through the Regional Behavioral Health Agency that serves Santa Cruz County. It should be noted that, although the telephone number for Nursewise was posted in the facility, the residents interviewed seemed to be unaware of it. The PREA pamphlet distributed to residents states that they can "call the Hotline" to report, but it does not provide a number. It is recommended that the pamphlet be amended to include that information and that the PREA education provided residents be modified to emphasize the availability of the hotline.

Staff may also make private reports of sexual abuse or harassment by contacting Nursewise or the state child abuse hotline. Again, the staff interviewed did not seem clear on this point, and it should be emphasized in staff PREA training.

### **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 procedure for grievances related to allegations of sexual abuse or sexual harassment is set out in the JDSO PREA policy at III A 20.3. A review of the relevant portions of the policy reveals the inclusion of all of the various provisions of this standard: there is no time limit on grievances regarding sexual abuse; a resident is not required to use any informal grievance process or attempt to resolve any such incident with the staff; a grievance need not be submitted to a staff member who is the subject of the complaint, nor are such grievances referred to the subject of the complaint. In addition, time frames for resolving grievances are well within the 90 days required in paragraph (h) of this Standard, having been developed for a detention center whose average length of stay is approximately 16 days. The procedure provides for third parties filing reports or assisting residents in doing so, and when a parent or legal guardian of a youth files a grievance alleging sexual abuse, its processing is not conditioned upon the resident's agreement to pursue it. The policy also provides emergency grievance procedures, which are consistent with the requirements in paragraph (f) of this Standard. Finally, a resident may be disciplined for filing a grievance alleging sexual abuse only when the agency establishes that the grievance was filed in bad faith.

The facility reported no grievances or reports alleging sexual abuse or sexual harassment in the past 12 months.

### **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.**

Agency Policy III A 20. 14 requires compliance with the provisions of this Standard, and administrators report that Nursewise, a private agency with which the facility has a contract, in fact provides the services. The telephone number for Nursewise is posted in various locations around the facility. However, as of the on-site audit, the agency had not entered into a memorandum of understanding with Nursewise or any other agency, nor did it provide written evidence of unsuccessful efforts to enter into a memorandum of understanding, as mandated by paragraph (c) of this standard.

During the corrective action period, the agency successfully negotiated and entered into a memorandum of understanding (MOU) with Community Health Associates. The MOU, executed April 4, 2016, provides for Nursewise to serve as a crisis line for the initiation of services in the event of sexual assault of a resident, crisis intervention services, including risk assessments, and confidential emotional support services related to sexual abuse.

Agency policy provides residents with reasonable confidential access to their attorneys by telephone or in person. The facility maintains a visitation room expressly for that purpose. Residents have access to their parents via weekly visitation and a minimum of one phone call per week. All of the residents interviewed confirmed that the facility provides access to attorneys and parents/guardians as set out in policy and described by administrators.

### Standard 115.354 Third-party reporting

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

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

The agency website contains its PREA policy, which provides information for third party reporting of sexual abuse and sexual harassment, thus satisfying this Standard. However, it is recommended that the agency provide this information separately within the PREA section of its website, so it is more easily accessible to the third parties who might take advantage of it.

### 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.**

Agency policy thoroughly incorporates the requirements of this Standard at III A 20.4. It requires all staff to report immediately any knowledge, suspicion or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in any facility, retaliation against residents or staff who reported such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Staff are also required to comply with mandatory reporting laws. All of the staff members I interviewed expressed awareness of those responsibilities. Policy III A 20.4 also prohibits staff from revealing any information related to a sexual abuse report, except designated supervisors or officials, designated state agencies, or, as specified elsewhere in policy, to make treatment, investigation and other security management decisions.

Medical and mental health practitioners are required to report sexual abuse in accordance with this standard and are required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality. In interviews, practitioners and residents alike expressed awareness of the practitioners' duty to report incidents of sexual abuse.

Policy also requires that the facility head or designee promptly report any allegation of sexual abuse to the Chief Probation Officer, as well as the alleged victim's parents or legal guardian. Likewise, if the alleged victim is under the guardianship of the Arizona Department of Child Safety, notification must be given the caseworker. Notification must also be given the the resident's attorney. Finally, policy requires all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, be given to the facility's investigator.

As previously noted, the facility had no reports of allegations of sexual abuse or harassment during the reporting period.

#### Standard 115.362 Agency protection duties

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

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

The agency reported no incidents where it learned that a resident was subject to imminent sexual abuse during the reporting period. However, policy directs that should such circumstances arise, the agency must take immediate action to protect the resident. (Pol. III A 20.5) All of the administrators and staff members who were interviewed during the site visit expressed knowledge of this requirement.

#### 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 reported no incidents of receiving an allegation that a resident was sexually abused while confined at another facility. That circumstance is covered in Pol. III A 204, however. The policy section appropriately incorporates all of the requirements found in 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.**

Due to the small size of the SCCJDC, all detention officers are considered to be first responders. The responsibilities of staff acting as first responders upon learning of an allegation of sexual abuse are listed in Pol. III A 20.11, which lists all of the requirements set out in his standard. Interviews of staff members during the site visit reflected their general awareness of those mandates.

Prior to the site visit, the facility provided a checklist for first responders entitled "Preservation of Evidence of Sexual Assault." However, that checklist contained an item inconsistent with both paragraph (a)(3) of this Standard, as well as parallel language in Pol. III A 20.11. The Standard provides that when abuse occurs within a time period that still allows for the collection of evidence, the first responder must request, not require, that the alleged victim not take actions that could destroy evidence, such as washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. Step Two on the first responders' checklist, as originally provided, instructs them to ensure that the alleged victim not take any of those actions.

During the corrective action period, the facility amended the checklist to correct the error. The checklist now provides that a first responder request that an alleged victim of sexual assault not engage in any of the enumerated activities that could destroy evidence.

#### **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.**

Although the agency had a checklist for first responders at the time of the site visit, as discussed in connection with the Standard 115.364, above, lacked a comprehensive written plan to coordinate actions among first responders, medical and mental health practitioners, investigators, and facility leadership, in response to an incident of sexual abuse. During the corrective action period, the facility wrote and implemented the required institutional plan. The plan provided the auditor was sufficiently comprehensive so as to satisfy this Standard, specifically setting out in a checklist format the responsibilities of first responding staff, the shift supervisor, the detention supervisor and administrators, in the event of a sexual assault.

#### **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.**

NA The agency does not engage in collective bargaining with its employees.

#### **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.**

Facility policy incorporates all of the provisions of this Standard at III A 20.5. The PREA Coordinator/Deputy Chief Probation Officer has been designated to monitor for retaliation in the event of a report of sexual abuse and sexual harassment. When interviewed, the PREA Coordinator was familiar with his obligations under this Standard.

#### **Standard 115.368 Post-allegation protective custody**

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

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

The facility has not had any incidents of sexual abuse so as to trigger the provisions of this Standard. However, facility policy incorporates this Standard at III A 20.10, which sets out the requirements for any use of protective isolation. In any event, "isolated" residents at SCCJDC are merely housed in designated rooms on the regular units. They continue to program normally with the other residents.

#### **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.**

There were no reports of sexual abuse or sexual harassment during the reporting period, and therefore there were no reports to review. However, facility policy incorporates the requirements of this Standard at III A 20.12. The facility has a relationship with the Nogales Police Department, which would be responsible for any criminal investigation.

An internal investigator would conduct the administrative investigation into allegations of sexual abuse or sexual assault. When interviewed, the investigator reported not having received any special training in sexual abuse investigations involving juvenile victims, as required by paragraph (b) of this Standard. However, during the corrective action period, the investigator completed a course on "Gender Responsive Strategies - Juveniles," offered by the National PREA Resource Center, as noted in a memo dated April 12, 2016. That course was in addition to the ten courses the investigator completed, as described in the discussion of Standard 115.334, above.

**Standard 115.372 Evidentiary standard for administrative investigations**

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

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

The agency has adopted a preponderance of the evidence standard for determining whether allegations of sexual abuse or sexual harassment are substantiated. (Pol. III A 20.12)

**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 had no reports or allegations of sexual abuse during the reporting period, and therefore there were no investigations to review. However, Policy III A 20.12 fully incorporates the requirements of this Standard, and administrators demonstrated their knowledge of them when interviewed.

**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.**

All of the provisions of this Standard have been incorporated verbatim into agency policy at Pol. III A 20.13. There were no instances of staff being disciplined for sexual abuse or sexual harassment during the reporting period.

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

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

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

The provisions of this Standard have been incorporated verbatim into agency policy at Pol. III A 20.13. There were no reported incidents of sexual abuse or sexual harassment involving contractors or volunteers during the reporting period.

**Standard 115.378 Disciplinary sanctions for residents**

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

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

Agency policy incorporates all of the provisions of this Standard at Pol. III A 20.13. There were no incidents of sexual abuse by residents during the reporting period.

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

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

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

The agency states that screening of residents during the past 12 months revealed no known cases of residents who were prior victims of sexual abuse or who previously perpetrated sexual abuse, either in an institution or in the community. The absence of detainees who were identified to have been prior victims is, at the least, unusual for a detention facility and may be the result of the lack of the objective screening tool required by Standard 115.341. Nonetheless, Policy III A 20.10 appropriately incorporates the requirements of this Standard regarding the provision of mental health services to residents whose screening disclosed having been a previous victim or perpetrator of sexual abuse.

Because by Arizona law, residents of the facility must be under the age of 18, there is no informed consent requirement before reporting information about prior sexual victimization that did not occur in an institutional setting.

**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.**

Medical and mental health services at the facility are coordinated by a registered nurse and a contract psychiatrist, each of whom was interviewed during the site visit. In their interviews, they confirmed that resident victims of sexual abuse would receive, without cost to the resident, timely unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which would be determined by medical and mental health practitioners using their professional judgment.

Detention officers, who would act as first responders in the event of an incident of sexual abuse, reported that they would protect the victim and immediately notify the appropriate medical and mental health practitioners, when no nurse was on duty. The facility nurse reported that resident victims would be offered timely access to emergency contraception and sexually transmitted infections prophylaxis, where medically appropriate.

**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 provisions of this Standard are incorporated in agency Policy III A 20.14. In addition, the facility's registered nurse confirmed that it would offer medical evaluation and, as appropriate, treatment to any resident who has been victimized by sexual abuse in any confinement facility. Agency administrators stated that the facility would similarly offer mental health evaluation and appropriate treatment to any such residents. The average length of stay at the SCCJDC is short -- less than 20 days -- thus limiting the ongoing treatment that would be offered. Still, the facility would offer, to the extent possible, follow-up services, treatment plans, and, when necessary, referrals for continued care following a resident's placement in other facilities or release from custody. The facility nurse and contract psychiatrist confirmed that all services provided would be consistent with the community level of care.

Resident female victims of sexual abuse while incarcerated would be offered pregnancy tests, where appropriate, and should pregnancy result, such victims would receive timely access to all lawful pregnancy-related medical services. All resident victims of sexual abuse while incarcerated would be offered tests for sexually transmitted infections as medically appropriate.

All treatment services provided by the facility are offered without cost to residents. The facility nurse stated in her interview that resident victims of sexual abuse would receive services without regard to whether the victim named the abuser or cooperated with any investigation.

The facility would attempt to conduct a mental health evaluation of any known resident-on-resident abuser within 60 days of learning of such abuse history and would offer treatment when deemed appropriate by mental health practitioners.

### 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 has designated a sexual incident review team, which will conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, unless the allegation is determined to be unfounded. The team consists of the Chief Probation officer, Chief Deputy Probation Officer, and the detention administrator. Provisions for the establishment of the review team and its processes are found in Policy III A 20.15. The policy incorporates all of the requirements set out in this Standard. Because there were no allegations of sexual abuse during the reporting period, there were no review team reports or findings to examine.

### Standard 115.387 Data collection

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

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

Policy III A 20.15 incorporates the requirements of this Standard. The data collected for the 2013 and 2014 can be viewed on the agency website. In neither year were there any incidents of sexual abuse. The facility reports that the Department of Justice has not requested the provision of data on sexual abuse.

### Standard 115.388 Data review for corrective action

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

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

Policy III A 20.15 incorporates the requirements of this Standard. However, there have been no incidents of sexual abuse to assess. Therefore, the report published on the agency website cannot identify problem areas or corrective actions taken as a result any analysis of the data, nor are there any specifics that need redacting. The report that appears on the agency website received the approval of the agency head.

**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)

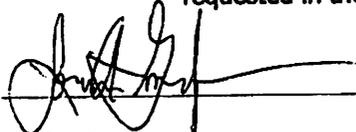
**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These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

Agency Policy III A 20.15 requires that the data collected pursuant to Standard 115.387 be securely retained for 10 years, consistent with paragraphs (a) and (d) of this Standard. The same policy provision requires that the data be published on the agency website, and the auditor was able to view it there. There are no personal identifiers found within the published data.

**AUDITOR CERTIFICATION**

I certify that:

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

  
\_\_\_\_\_  
Auditor Signature

June 7, 2016 \_\_\_\_\_  
Date