PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: 06-09-2017

Auditor Information			
Auditor name: David "Will" Weir			
Address: PO Box 1473; Raton NM 87740			
Email: will@preaamerica.com			
Telephone number: 405-945-1951			
Date of facility visit: 04-26-2017			
Facility Information			
Facility name: San Juan County Juvenile Services			
Facility physical address: 851 Andrea Drive; Farmington, NM 87401			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 505-324-5800			
The facility is:	☐ Federal	☐ State	☒ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☐ Correctional	☒ Detention	☒ Other
Name of facility's Chief Executive Officer: Traci Neff, Administrator			
Number of staff assigned to the facility in the last 12 months: 17			
Designed facility capacity: 47			
Current population of facility: 15			
Facility security levels/inmate custody levels: medium			
Age range of the population: 11-19			
Name of PREA Compliance Manager: Shane Starr		**Title:** Quality & Compliance Coordinator	
Email address: sstarr@sjcounty.net		**Telephone number:** (505)324-5853	
Agency Information			
Name of agency: San Juan County Juvenile Services			
Governing authority or parent agency: *(if applicable)* Click here to enter text.			
Physical address: 851 Andrea Drive; Farmington NM 87401			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: (505)324-5800			
Agency Chief Executive Officer			
Name: Traci Neff		**Title:** Administrator	
Email address: tneff@sjcounty.net		**Telephone number:** (505)324-5853	
Agency-Wide PREA Coordinator			
Name: Shane Starr		**Title:** Quality & Compliance Coordinator	
Email address: sstarr@sjcounty.net		**Telephone number:** (505)324-5853	

AUDIT FINDINGS

NARRATIVE

PREA America, LLC., was retained by Administrator Traci Neff on March 9, 2017 to perform the PREA audit of San Juan County Juvenile Services. Audit notices went up by March 15 announcing the audit to residents and staff and providing a confidential way for them to contact the auditor. The Pre Audit Questionnaire and supporting documents were received by the audit team on April 11. Additoinal documentation continued to be received throughout the audit process. The audit team and PREA Coordinator Shane Starr has had numerous phone calls and email exchanges clarifiying information. The audit team consisted of PREA Auditor Will Weir and Project Manager Tom Kovach. The onsite audit was conducted April 26.

The morning of April 26 the audit team met with PREA Coordinator Shane Starr who gave a tour of the facility and introduced the team to the staff and administrators. The team was given staff and resident rosters. Random staff were selected for interviews. A total of 13 detention officers, specialized staff and administrators were interviewed. They indicated full commitment to PREA and good grasp of the policies. The day of the audit started with the facility having a population of 17 residents, but two left and 15 were present for possible interviews. 10 were randomly selected and interviewed. The audit team found the residents to be well informed about PREA. Most of them even knew that outside services would be available for victims of sexual abuse or harassment. Their answers to the interview questions indicated PREA policies are being followed at the facility in all areas including supervision and searches. They indicate the facilty staff will help residents who need it but are strict and do not play favorites. They report specific and effective efforts staff make to de-escalate residents who have become upset and times when staff help them learn better coping skills. An Exit Conference was held at the end of the day attended by the audit team, Administrator Traci Neff, PREA Coordinator Shane Starr and Deputy Administrator Bowen Belt. The audit team was impressed by the professionalism of the staff and the organizational skills of the administration and express gratitude for their help in making the audit process flow smoothly. The team also discussed the positive morale of the residents who generally said they felt fortunate to be at San Juan Juvenile Services rather than other places they might have ended up, because they are getting help they need. They can generally trust staff to keep their best interests in mind.

Documentation reviewed includes: Pre-Audit Questionnaire; PREA Compliance Policies; Sexual Misconduct (1st Responder Duties); New Mexico Association of Counties HR Policy; Investigation Report Checklist; PREA screening forms and examples; facility schematic; Memorandum of Understanding with Sexual Assault Services of Northwest New Mexico; Staff rosters and schedules; Survey of Sexual Victimization; policies regarding searches, grievances, and supervision of children; Incident Review Form; PREA training sign in sheets for staff, contractors, and volunteers; employee background checks; Mission Statement; population reports; PREA Report Checklist; Staff Training PowerPoint; Camera Callups and Placements; Staffing Plan and Review; Retaliation Monitoring Forms; Programming; Resident rosters and verification of PREA education; and various other PREA forms, documentation, postings, and notices.

DESCRIPTION OF FACILITY CHARACTERISTICS

San Juan Juvenile Detention Facility is housed in a single large building which is divided into a judicial section, administration and detention. The judicial section is on the left as you enter the building and go into the large lobby area. There is a visitation section, booking area and medical section that are along a long corridor that has dining and classrooms on the other side along with a library and two detention pods which are octagonal but have two "v" shaped longer sides with shorter sides at the base of the "v" and connecting the two "v" shapes which are on their sides. The pods have single bed cells with day rooms and most are wet cells. There are control areas in the middle of the two pods. Administration is a series of offices and cubicles which are in a large open area that also houses a conference room.

There is a large outdoor recreational area behind the pods which is fenced and secured. It has a gardening area and a large playing field. The pods also open to indoor recreational areas that are adjacent to the vestibule that leads to the pods.

There are multiple cameras which record for several days allowing review of any incidents.

SUMMARY OF AUDIT FINDINGS

San Juan Juvenile Services received its on-site PREA audit on April 26, 2017. PREA Auditor Will Weir has verified compliance through interviews and a review of documents and found the facility to be compliant with all PREA Standards based on their successful completion of the PREA Audit process.

Number of standards exceeded: 0

Number of standards met: 41

Number of standards not met: 0

Number of standards not applicable: 0

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

San Juan County Juvenile Services has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment, and a policy outlining how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment and it includes sanctions for those found to have participated in prohibited behaviors. The policy includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents. The agency employs and designates an upper-level, agency-wide PREA coordinator who has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in the facility. Quality and Compliance Coordinator Shane Starr is the PREA Coordinator. He reports to Administrator Tracy Neff. Residents interviewed indicated that the facility is safe and that the staff are trustworthy and protect them. Residents remember being taught the zero tolerance policy and that there is multiple ways to report, and that they cannot be retaliated against for reporting.

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.

Although San Juan County Juvenile Services contracts to house inmates for other entities, not vice versa, their policy includes provisions for this standard, specifying that they will include in any new or renewing contract with an entity which will house San Juan County youth, an obligation to adopt and comply with PREA standards, and that they will monitored for compliance as required in the PREA Standards.

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

San Juan Juvenile Services develops, documents, and makes its best efforts to comply on a regular basis with a staffing plan that provides for adequate levels of staffing, and video monitoring, to protect residents against abuse. Each time the staffing plan is not complied with, the facility documents and justifies all deviations from the staffing plan. The average daily number of residents is 20.5 and this is what the Staffing Plan is based on. Minimum staffing is usually 8 residents to 1 staff during the day and 12 to 1 at night. At least once every year the agency reviews the staffing plan considering all relevant factors, to see whether adjustments are needed to the staffing plan: in prevailing staffing patterns; the deployment of monitoring technology; or the allocation of agency resources to commit to the staffing plan to ensure compliance with the staffing plan. The facility requires that intermediate-level or higher-level staff conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment. There is a policy to prohibit staff from alerting other staff members that these rounds are occurring, unless such announcement is related to the operational functions of the facility. Compliance with this standard was verified by review of staffing plans, reviews, policy and logs, as well as through interviews conducted. In calculating adequate staffing levels and determining the need for video monitoring, the facility considers: (1) Generally accepted juvenile detention and correctional/secure residential practices; (2) Any judicial findings of inadequacy; (3) Any findings of inadequacy from Federal investigative agencies; (4) Any findings of inadequacy from internal or external oversight bodies; (5) All components of the facility's physical plant (including "blind spots" or areas where staff or residents may be isolated); (6) The composition of the resident population; (7) The number and placement of supervisory staff; (8) Institution programs occurring on a particular shift; (9) Any applicable State or local laws, regulations, or standards; (10) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and (11) Any other relevant factors.

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 does not conduct any kind of cross-gender searches of residents except in exigent circumstances (which are fully documented and justified) or when performed by medical practitioners. According to interviews and documentation provided, none of these have been conducted in the past year. Residents shower one at a time, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. Staff of the opposite gender announce their presence when entering a resident housing unit. Staff are forbidden from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner. The agency has trained security staff in how to conduct cross-gender pat-down searches in exigent circumstances, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. Interviews with residents indicated no worries about any part of this standard being violated. Residents consistently stated they are not searched or viewed by opposite gender staff at all. They said searches are by a staff of the same sex and are done appropriately.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The 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 agency has established procedures to provide residents with limited English proficiency equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Agency policy prohibits use of resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under ß 115.364, or the investigation of the resident's allegations. In the past 12 months, there have been no instances where resident interpreters, readers, or other types of resident assistants have been used 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 under ß 115.364, or the investigation of the resident's allegations. Staff and residents indicate the agency will go the extra mile to assist anyone to understand what they need to understand in order to be safe and exercise their rights. Staff interviews and policy reviews indicate efforts to provide equal opportunity have been required and practiced in the agency culture for a number of years.

Standard 115.317 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency policy prohibits hiring or promoting anyone who may have contact with residents, and prohibits enlisting the services of any contractor who may have contact with residents, who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section. The Agency policy requires the consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. Policy requires that before it hires any new employees who may have contact with residents, San Juan County Juvenile Services conducts criminal background record checks, consults any child abuse registry maintained by the State or locality in which the employee would work; and consistent with Federal, State, and local law, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. During the past 12 months all staff and contract persons who have been hired, who may have contact with residents, have had criminal background record checks. The Agency policy requires that ongoing beckground checks be conducted through CYFD's RAP Back program which notifies them of arrests and changes in criminal history record information. The Agency policy states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. Unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work. Compliance with this standard was verified through a close reading of policy and other documentation provided, as well as a review of random personnel files pulled at the auditor's request, and through interviews with administrators.

Standard 115.318 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

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

The agency has not acquired a new facility or made a substantial expansion or modification to existing facilities since August 20, 2012. However, the facility has installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology. Documentation provided, as well as interviews with administrators, indicate sexual safety is considered when updates occur. The video monitoring system was demonstrated during the facility tour and is expandable.

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.

CYFD, OIG and San Juan County Sheriff's Office are responsible for conducting administrative sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). When conducting a sexual abuse investigation, the investigators follow a uniform evidence protocol that is developmentally appropriate for youth, adapted 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. The facility offers all residents who experience sexual abuse access to forensic medical examinations, without cost. Where possible, examinations are conducted by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). When SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations. The facility documents efforts to provide SANEs or SAFEs. During the past 12 months there were no forensic medical exams conducted. The facility attempts to make a victim advocate from a rape crisis center available to the victim, in person or by other means and these attempts are documented. If and when a rape crisis center is not available to provide victim advocate services, the facility provides a qualified staff member from a community-based organization or a qualified agency staff member. The auditor spoke with Will Bates, Clinical Director of the Sexual Assault Services of Northwest New Mexico, to verify the Memorandum of Understanding the facility has with the agency. The understanding has been in place for over a year and has been working very well. He believes the youth at the facility has access to their number and call it when they need or want to. If the youth calls the Crisis Hotline (505-326-4700) believing it is one of the reporting numbers, this is no problem, because SASNWNM has established a reporting protocol regarding allegations of sexual abuse or harassment that are alleged to have occurred in correctional facilities. They are trained regarding PREA and will help the caller understand what they need to understand and get appropriate care and followup. SASNWNM would make sure the youth knows the limits to confidentiality and would make the report as well as providing confidential advocacy services, if the youth desires the services. Mr. Bates has no concerns about the care they receive at the facility. Deputy Director Bowen Belt, and all the other staff at San Juan County Juvenile Services, are always very quick to return calls or respond to inquiries by SASNWNM. The facility corridinates and collaborates well with SASNWNM and there are no barriers to youth who are residents at the facility receiving the same care they would receive if not incarcerated. If a youth needs follow up care from SASNWNM, arraingements have been made so that the youth will be discretely transported to the SASNWNM facility where a full range of care is available, including medical examinations.

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. According to information provided in the Pre-Audit Questionnaire, as well as during interviews with both staff and residents, it appears there have been no allegations of sexual abuse or sexual harassment received in the past year, therefore there have been no referrals for investigation or prosecution. Policy requires that allegations of sexual abuse or 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 policy regarding the referral of allegations of sexual abuse or sexual harassment for a criminal investigation is published on the agency (CYFD) website and is made publicly available at the facility and by other means as well. Basic PREA information is provided on the San Juan County website. The agency documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigation. The Facility Administrator and PREA Compliance Manager verified their understanding of this standard and their intention and commitment to make sure these policies and procedures are followed.

Standard 115.331 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

As verified by interviews with staff, San Juan County Juvenile Services trains all employees who may have contact with residents on the following required matters: zero-tolerance policy for sexual abuse and sexual harassment; how to fulfill responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; residents' right to be free from sexual abuse and sexual harassment; the right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment; the dynamics of sexual abuse and sexual harassment in juvenile facilities; the common reactions of juvenile victims of sexual abuse and sexual harassment; how to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents; how to avoid inappropriate relationships with residents; how to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities, and including relevant laws regarding the applicable age of consent. Between trainings, the agency provides employees with refresher information about current policies regarding sexual abuse and sexual harassment. The agency documents that employees understand the training they have received through employee signature. Random employee files, training documentation, and handouts used in training, were reviewed by the audit team.

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.

Volunteers and contractors who will have contact with residents have been trained on their responsibilities under the agency policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. The level and type of training provided to volunteers and contractors is based on the services they will provide and level of contact they will have with residents. All volunteers and contractors who will have contact with residents will have at least been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents. The audit team reviewed documentation confirming that volunteers/contractors understand the training they have received.

Standard 115.333 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The residents receive information at time of intake about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. This information is provided in an age appropriate fashion. All current residents have been trained on PREA, according to documentation provided to the auditor and interviews conducted. All transfers are treated as admissions, so these residents get the same PREA training. The agency maintains documentation of resident participation in PREA education sessions and the auditor reviewed a sample of this documentation, as well as the resident training curriculum and handouts. The agency ensures that key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats. The agency provides resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills. Information received during the pre-audit process, as well as during the on-site audit, including interviews with staff and residents indicate the residents understand the zero tolerance policy and various ways to report.

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.

Agency policy requires that investigators are trained in conducting sexual abuse investigations in confinement settings. The training includes

techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.

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.

San Juan Juvenile Services has a policy related to the training of medical and mental health practitioners who work regularly at the facility. All 6 medical and mental health care practitioners who work regularly at this facility have received the training, but they do not conduct forensic exams, but would assist law enforcement if requested. The training teaches how to detect and assess signs of sexual abuse and sexual harassment; how to preserve physical evidence of sexual abuse; how to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and how and to whom to report allegations or suspicions of sexual abuse and sexual harassment. This was verified by a review of training documentation, policy and interviews.

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.

San Juan Juvenile Services has a policy that requires screening (upon admission to the facility or transfer from another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents. The policy requires that residents be screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their intake. Such assessments shall be conducted using an objective screening instrument. At a minimum, the agency shall attempt to ascertain information about: (1) Prior sexual victimization or abusiveness; (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse; (3) Current charges and offense history; (4) Age; (5) Level of emotional and cognitive development; (6) Physical size and stature; (7) Mental illness or mental disabilities; (8) Intellectual or developmental disabilities; (9) Physical disabilities; (10) The 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. This information is ascertained through conversations with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files. Controls are in place on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents. Interviews indicate the administrative staff communicate regularly and effectively, even after hours, to address a wide variety of concerns as well as any risk factors. They reassess when a resident is high risk and when new information regarding risk factors come to their attention.

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)

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The agency/facility uses information from the risk screening required by ß115.341 to inform housing, bed, work, education, and program assignments. The facility prohibits placing lesbian, gay, bisexual, transgender, or intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status. The facility prohibits considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. The agency or facility makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis. The facility uses all information obtained pursuant to § 115.341 and subsequently to make housing, bed, program, education, and work assignments for residents with the goal of keeping all residents safe and free from sexual abuse. 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. 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. A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration. Transgender and intersex residents shall be given the opportunity to shower separately from other residents.

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. The facility provides at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the facility. There are no residents detained solely for civil immigration purposes at this time. The agency has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. Staff are required to document verbal reports immediately. The facility provides residents with access to tools to make written reports of sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. The agency has also established procedures for staff to privately report sexual abuse and sexual harassment of residents. Postings around the facility instruct residents on the methods of reporting which include talking to a staff member or the PREA Coordinator. They are also given numbers for CYFD, OIG, and a confidential PREA line.

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 an administrative procedure for dealing with resident grievances regarding sexual abuse. The facility policy allows a resident to submit a grievance regarding an allegation of sexual abuse at any time regardless of when the incident is alleged to have occurred. There is no time limit for a resident to submit a grievance regarding an allegation of sexual abuse, and the resident is not required to use an informal grievance process, or otherwise to attempt to resolve with staff, an alleged incident of sexual abuse. The facility's policy allows a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint. The facility's procedure requires that a resident grievance alleging sexual abuse not be referred to the staff member who is the subject of the complaint. The facility has policy that requires that a decision on the merits of any grievance or portion of a grievance alleging sexual abuse be made within 90 days of the filing of the grievance. The facility notifies the resident in writing when the agency files for an extension, including notice of the date by which a decision will be made. The facility 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. Policy requires that if the resident declines to have third-party assistance in filing a grievance alleging sexual abuse, the agency documents the residents decision to decline. Policy allows legal guardians of residents to file a grievance, including appeals, on behalf of such resident, regardless of whether or not the resident agrees to having the grievance filed on their behalf. The agency has a policy for filing an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. These emergency grievances require an initial response within 48 hours and that a final agency decision be issue within 5 days. Interviews conducted, and documentation received, indicate there have been no grievances alleging substantial risk of imminent sexual abuse that were filed in the past 12 months. The agency has a policy that limits its ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith.

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The facility provides residents access to outside victim advocates for emotional support services related to sexual abuse by giving residents (by providing, posting, or otherwise making accessible) mailing addresses and telephone numbers (including toll-free hotline numbers where available) of local, State, or national victim advocacy or rape crisis organizations. Sexual Assault Services of Northwest New Mexico is the main source of advocacy and related services in the area and has an MOU with San Juan Juvenile Services which has been verified by the auditor.

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 or facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment by phone, email, in writing, and by personal contact. The agency (as well as CYFD) publicly distributes information on how to report resident sexual abuse or sexual harassment on behalf of residents.
The agency website: https://cyfd.org/facilities/prison-rape-elimination-act-prea provides the contact phone number and email for the PREA Coordinator.
The CYFD website: https://cyfd.org/facilities/prison-rape-elimination-act-prea
states the following:

How to Report Sexual Misconduct:

If you wish to report an alleged incident of sexual assault, sexual abuse, sexual misconduct or sexual harassment on behalf of an offender you may:

- Call the JJS PREA Coordinator: 1-505-469-7700
- Email the JJS PREA Coordinator: JJSPREA.Coordinator@state.nm.us
- Confidential Reporting: 1-855-563-5065

Criminal investigations of PREA allegations are investigated by the New Mexico State Police. Administrative investigations of PREA allegations are investigated by the CYFD Office of Inspector General or facility Grievance Officer.

Emergency Grievances at Secure Facilities

PREA defines an "emergency grievance" as an allegation that a client is subject to substantial risk of imminent sexual abuse. JJS documentation refers to "PREA emergency grievances" as substantial threats that include substantial risk of imminent physical and/or sexual abuse.
To report a substantial threat:

- Call the JJS Facility Confidential Reporting Number (1-855-563-5065), or
- Submit a grievance, or
- Notify an employee of the facility.

Anyone can call the JJS Facility Confidential Reporting Number or submit a grievance on a client's behalf.
The JJS Confidential Reporting Line and the facility Grievance Boxes are checked at least once every 24 hours.
When a substantial threat is received, the Superintendent/Office in Charge (OIC) of the facility is immediately notified, and immediate actions are taken to ensure the safety of the client who is the subject of a substantial threat. The Superintendent/OIC's immediate action may include notifying law enforcement and/or the on-call BH clinician, separating clients, separating clients and employees, and/or assigning one-on-one supervision.
Within 48 hours of receiving a substantial threat, the Superintendent/OIC meets with the client. The client explains the substantial threat and the resolution sought, and the Superintendent/OIC communicates the immediate action taken to address the substantial threat.

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.

Interviews with staff and administrators, as well as a review of policy, verify that all staff are required to report immediately: 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. They also must report any retaliation against residents or staff who reported such an incident. They

must report staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. The agency requires all staff to comply with any applicable mandatory child abuse reporting laws. Apart from reporting to designated supervisors or officials and designated State or local service agencies, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. Medical and mental health professionals are required to report sexual abuse to designated supervisors, as well as to the designated State or local services agency where required by mandatory reporting laws. Health professionals are required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality. Upon receiving any allegation of sexual abuse, the facility administrator will promptly assure a report of the allegation is made to the appropriate agency office and to the alleged victim's parents or legal guardians, unless the facility has official documentation showing the parents or legal guardians should not be notified. If the alleged victim is under the guardianship of the child welfare system, the report is be made to the alleged victim's caseworker instead of the parents or legal guardians. If a juvenile court retains jurisdiction over the alleged victim, the facility head or designee will also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation. All allegations of sexual abuse and sexual harassment are investigated.

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.

When the agency or facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident. Interviews indicate staff take this responsibility very seriously. In the past 12 months, there were no times the agency or facility determined that a resident was subject to substantial risk of imminent 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.

San Juan Juvenile Services policy requires that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the Facility Administrator must notify the head of the facility where sexual abuse is alleged to have occurred, as well as notifying the appropriate investigative agency. In the past 12 months, no allegations have been received that a resident was abused while confined at another facility. The agency policy requires that the facility head provides such notification as soon as possible, but no later than 72 hours after receiving the allegation. The agency or facility documents that it has provided such notification within 72 hours of receiving the allegation. Policy also requires that allegations received from other facilities/agencies are investigated in accordance with the PREA standards.

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 agency/facility has a first responder policy for allegations of sexual abuse. The agency policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to: preserve and protect any crime scene until appropriate steps could be taken to collect any evidence; request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. Interviews with staff indicate they understand first responder duties. The wording of first responder duties has recently been improved and redistributed to staff. Training logs and training curriculum indicate all duties are covered.

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 written institutional plan 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, and this was provided to the auditor.

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.

San Juan Juvenile Services maintains its ability to protect it's residents and employees from abusers. No collecting bargaining agreements hinder this process.

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.

San Juan Juvenile Services has a policy to protect all residents and staff or any cooperating individual who reports sexual abuse or sexual harassment or cooperates with sexual abuse or sexual harassment investigations from retaliation by other residents or staff. Staff member(s) or department(s) are charged with monitoring for possible retaliation. They monitor the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff. They will examine resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. They will continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need. In the case of residents, such monitoring will also include periodic status checks. The agency/facility acts promptly to remedy any such 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 has a policy that residents who allege to have suffered sexual abuse may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged. The facility policy requires that residents who are placed in isolation because they allege to have suffered sexual abuse have access to legally required educational programming, special education services, and daily large-muscle exercise. Although this is covered in policy, interviews indicate isolation is very unlikely to occur. In the past 12 months no residents who have alleged sexual abuse have been placed in isolation or segregated.

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.

CYFD and San Juan Juvenile Services have policies related to criminal and administrative agency investigations. The San Juan Sheriff's Department conducts criminal investigations. The agency does not terminate an investigation solely because the source of the allegation recants the allegation. Substantiated allegations of conduct that appear to be criminal are referred for prosecution. The agency retains all written reports pertaining to the administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. When the quality of evidence appears to support criminal prosecution, the investigative agency will conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution. The credibility of an alleged victim, suspect, or witness will be assessed on an individual basis and not be determined by the person's status as resident or staff. No polygraphs are required. Administrative investigations are conducted by the agency and include an effort to determine whether staff actions or failures to act contributed to the abuse. Such investigations will be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. Criminal investigations will be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible. Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution. The agency will retain all written reports for as long as the alleged abuser is incarcerated or employed by the agency, plus five years, unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention. The departure of the alleged abuser or victim from the employment or control of the facility or agency will not provide a basis for terminating an investigation. When outside agencies investigate sexual abuse, the facility will cooperate with outside investigators and will endeavor to remain informed about the progress of the investigation.

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.

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

Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

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

Policy requires that any resident who makes an allegation that he suffered sexual abuse 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. In the past 12 months there have been no investigations of alleged resident sexual abuse that were completed by the agency/facility. If an outside entity conducts such investigations, the agency requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation. Following a resident's allegation that a staff member has committed sexual abuse against the resident, the facility subsequently informs the resident (unless the facility has determined that the allegation is unfounded) whenever: The staff member is no longer posted within the resident's unit; The staff member is no longer employed at the facility; The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. Following a resident's allegation that he or she has been sexually abused by another resident in an agency facility, the agency subsequently informs the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or the agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. The agency has a policy that all notifications to residents described under this standard are documented.

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.

San Juan Juvenile Services staff are subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. In the past 12 months no staff from the facility were alleged to have violated agency sexual abuse or sexual harassment policies. Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

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.

Agency policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. Agency policy requires that any contractor or volunteer who engages in

sexual abuse be prohibited from contact with residents. In the past 12 months, no contractors or volunteers have been reported to law enforcement agencies and relevant licensing bodies for engaging in sexual abuse of residents. The facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

Standard 115.378 Disciplinary sanctions for residents

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

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

Policy review and interviews indicate: Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse. Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following a criminal finding of guilt for resident-on-resident sexual abuse. In the past 12 months there have been no findings of resident-on-resident sexual abuse that have occurred at the facility. Isolation is not used at the facility except in emergency circumstances since everyone has single cells. In the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, residents in isolation receive daily visits from a medical or mental health care clinician, but again. In the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, residents in isolation have access to other programs to the extent possible. In the past 12 months no residents have been placed in isolation as a disciplinary sanction for resident-on resident sexual abuse. The facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. The facility considers whether to require the offending resident to participate in such interventions as a condition of access to any rewards-based behavior management system or other behavior based incentives. Access to general programming or education is not conditional on participation in such interventions. The agency disciplines residents for sexual contact with staff only upon finding that the staff member did not consent to such contact. San Juan Juvenile Services prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation. The agency prohibits all sexual activity between residents and disciplines residents for such activity, but deems such activity to constitute sexual abuse only if it determines that the activity is coerced.

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.

All residents at this facility who have disclosed any prior sexual victimization, or prior sexual perpetration, during a screening pursuant to ß115.341 are offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. In the past 12 months, all residents regardless of disclosure for prior victimization or perpetration during screening were offered a follow up meeting with a medical or mental health practitioner. Mental health providers maintain secondary materials documenting compliance with the above required services. The information shared with other staff is strictly limited to informing security and management decisions, including

treatment plans, housing, bed, work, education, and program assignments, or as otherwise required by federal, state, or local law.

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.

Resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. Medical and mental health staff maintain secondary materials documenting the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning sexually transmitted infection prophylaxis. Treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Verification of compliance with this standard at San Juan Juvenile Services was obtained through a review of policy and interviews with investigators and administrators committed to the health and safety of the residents.

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 offers 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. Resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate. Treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. The facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such history. 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. The facility provides such victims with medical and mental health services consistent with the community level of care. Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests. If pregnancy results from abuse, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancyrelated medical services. The auditor verified that these services are available to residents through services in the Farmington area. The Coordinated Response Plan calls for Sexual Abuse Exams to be coordinated through Sexual Assault Services of Northwest New Mexico, which is in Farmington.

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 conducts a sexual abuse incident review at the conclusion of every sexual abuse criminal or administrative investigation, unless the allegation has been determined to be unfounded. The facility conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation. The sexual abuse incident review team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners. The review team considers whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; considers whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or, gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; examines the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; assesses the adequacy of staffing levels in that area during different shifts; assesses whether monitoring technology should be deployed or augmented to supplement supervision by staff; and prepares a report of its findings, including but not necessarily limited to determinations made pursuant to this section, and any recommendations for improvement, and submits such report to the facility head and PREA compliance manager. The facility implements the recommendations for improvement, or documents its reasons for not doing so. The facility has not completed many of these reviews to date (none in the past year) due to not having many abuse allegations. However, Administrator Traci Neff and PREA Coordinator Starr indicate this process naturally flows within their commitment to self examination and quality improvement.

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The agency collects accurate, uniform data for every allegation of sexual abuse at facilities using a standardized instrument and set of definitions. The standardized instrument includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. The agency aggregates the incident-based sexual abuse data at least annually in cooperation with CYFD, who takes the lead in this endeavor. The agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews and provides this information to the State. The report can be found at: https://cyfd.org/facilities/prison-rape-elimination-act-prea

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.

SJCJS and CYFD reviews data collected and aggregated pursuant to ß115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training, including: Identifying problem areas; taking corrective action on an ongoing basis; and 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. The annual report includes a comparison of the current year's data and corrective actions with those from prior years. Annual reports provide an assessment of the agency's progress in addressing sexual abuse. The report is available to the public at least annually. The annual reports are approved by the agency head. When the agency redacts material from an annual report for publication the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility.

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.

SJCJS ensures that incident-based and aggregate data are securely retained. Policy requires that aggregated sexual abuse data be made readily available to the public, at least annually. This is the facility's first PREA Audit and the collection and publication of this data has only recently began and they rely on the New Mexico Children Youth and Families Department (CYFD) for support and assistance with this process. Before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers. The agency maintains sexual abuse data collected pursuant to ß115.387 for at least 10 years after the date of initial collection, unless Federal, State or local law requires otherwise. Interviews with administrators who explained their system and also verified a broad commitment to confidentiality that is reflected in their written agency policy, indicate this standard is being followed to the best of their ability and understanding.

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.

D. Will Weir 06-09-2017

Auditor Signature Date