PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: November 3rd, 2015

Auditor Information			
Auditor name: Jerome K. Williams			
Address: PO Box 81656 Austin, Texas 78708			
Email: Jerome.williams@tjjd.texas.gov			
Telephone number: 512-490-7671			
Date of facility visit: October 7th thru 9th, 2015			
Facility Information			
Facility name: Lyle B. Medlock Residential Treatment Center			
Facility physical address: 1508 E. Langdon Rd. Dallas, Texas 75241			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 972-227-9700			
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: Marilyn Boss, Superintendent			
Number of staff assigned to the facility in the last 12 months: 74			
Designed facility capacity: 96			
Current population of facility: 67			
Facility security levels/inmate custody levels: Secure, Post Adjudication Correctional Facility, Progressive Sanctions Level 5			
Age range of the population: 13-17 years of age			
Name of PREA Compliance Manager: Roy Gowan		**Title:** Assistant Superintendent	
Email address: roy.gowan@dallascounty.org		**Telephone number:** 972-227-9723	
Agency Information			
Name of agency: Click here to enter text.			
Governing authority or parent agency: *(if applicable)* Texas Juvenile Justice Department			
Physical address: 11209 Metric Blvd Building H, Suite A Austin, Texas 78758			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: Click here to enter text.			
Agency Chief Executive Officer			
Name: Dr. Terry S. Smith		**Title:** Executive Director	
Email address: terry.smith@dallascounty.org		**Telephone number:** 214-698-2223	
Agency-Wide PREA Coordinator			
Name: Leah Probst		**Title:** Quality Assurance	
Email address: leah.probst@dallascounty.org		**Telephone number:** 214-698-4479	

AUDIT FINDINGS

NARRATIVE

The PREA Audit was conducted on October 7th to the 9th, 2015 at the Lyle B. Medlock Treatment Center in Dallas, Texas, a county-run facility. The audit was conducted by the certified PREA Auditor for Juvenile & Adult Facilities, Jerome K. Williams. Pictures of the Audit Notice posting were sent prior to this audit and were seen throught the facility on colored paper.

Following the entrance meeting a thorough tour of the facility was provided by the PREA Coordinator, the Facility Superintendent, the Deputy Director of Institutional Services, the PREA Compliance Manager, the Detention Manager, the Quality Assurance JPO, the Case Manager Supervisor and the Quality Control and Compliance Auditor from Cameron County who was visiting the facility to observe the audit process. Continuing on this first day of the audit a comprehensive listing of the youth and staff was requested and provided for the interviews with the necessary adjustments being made to compensate for schedule changes, etc. During the tour random interviews were conducted of youth and staff to ascertain their knowledge of the PREA Standards, reporting procedures, services available and their reporting responsibilities. A total of 10 youths were interviewed during this on site visit and they all acknowledged receiving PREA training, written information (i.e. handbook, Hotline numbers, observing Break the Silence posters, etc.) and were informed of related policies that outlines the facility's zero tolerance towards sexual abuse, sexual harassment and their right to be free from retaliation for reporting sexual abuse and sexual harassment allegations.

A total of 12 specialized staff members were interviewed comprising of the Superintendent, the PREA Coordinator, a First Responder, Medical and Mental Health staff, Intake staff, Intermediate Level Staff, the Internal Investigator, a Volunteer, Contract Administrator, the Human Resource Specialist, and a member of the Sexual Abuse Incident Review Team were interviewed. A total of 8 random staff members were interviewed although 10 were scheduled (two part time employees did not show during audit period). The staff interviewed were knowledgeable of their responsibilities in reporting sexual abuse and sexual harassment allegations, staff negligence and the steps required in monitoring for staff and or youth for retaliation. When questioned about evidence preservation, all the staff responses reflected their knowledge of the agency's policy and their first responder duties. There were no SAFE and or SANE personnel at this facility but they were available at the Parkland Health and Hospital System. The personnel indicated that they are aware of the SANE protocol if the facility were bring a youth there for a SANE examination.

The auditor reviewed blind spots, staff placement, supervisory presence, toured the facility and reviewed documentation to assist in determining PREA standard compliance. Upon completion of the audit an exit meeting was held with the Facility Superintendent, the Deputy Director of Institutional Services, the PREA Compliance Manager, the Detention Manager, the Quality Assurance JPO, the Case Manager Supervisor and the Quality Control and Compliance Auditor from Cameron County who was visiting the facility. The facility was provided with a general overview of the audit process, audit highlights which included a synopsis of the files, documentation review, staff and youth interviews and of the facility tour. During the debriefing the auditor informed them that in the event there were standards that were not met that he would work closely with the agency's PREA Coordinator to facilitate PREA compliance within the 180 day corrective action period, if applicable. Furthermore, he informed them that once compliance is achieved that the agency will be required to post the Final Report upon issuance on the agency's website within two weeks.

This report is considered to be the Final PREA Audit Report.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Lyle B. Medlock Residential Treatment Center is a designed 96 bed post adjudicated, long-term secure facility holding male youths from ages 13 through 17 located in Dallas, Texas. Their mission is to provide highly structured care and supervision for those youth who have committed offenses that requires secure placement. The youth housed at the facility are court ordered and placed by the Dallas County Juvenile District Courts. Youth attend classes on site that are provided by the Academy for Academic Excellence. Youth participate in group counseling, individual counseling, life-skills counseling, recreational activities, drug education, and other programs designed to assist with basic skills related to health, hygiene, independent living and employment. The facility is located in Dallas, Texas and services youths from Dallas County and some surrounding counties.

On the day of the audit there were 64 youths assigned to the facility in totality. The facility provides professional custodial care, crisis intervention, counseling, education, and other services through counselors, clinical staff, and a licensed psychologist that provide a wide variety of treatment services grounded in evidence-based principles and cognitive behavioral interventions including relationship-based and strength based services. They also provide individual, family and group counseling, substance abuse treatment, psychological evaluations, aggressive management, case management, individualized education, community service, life skills, drug education, Anti-victimization, and social skills for daily living.

The facility has a multipurpose room that serves as an inside gymnasium and dining hall, 1 kitchen area, 9 classrooms, 8 dormitories (housing areas), 1 administrative area, 1 medical clinic, a large outside court for recreation, numerous offices, 1 intake area and 1 shared control communication center. The showers were located in the corner of each housing unit where the cameras cannot view inside the shower or restroom areas. Shower routines are conducted by male staff only for the youth in each housing unit. Staff of the opposite gender do knock and announce their presence before entering the housing unit of the opposite gender especially during shower, changing and restroom routines. This practice was observed during the tour of the facility. The facility was operating safely and observably clean throughout during the days of this on site audit visit.

SUMMARY OF AUDIT FINDINGS

The Lyle B. Medlock Residential Treatment Center, which is one of two facilities on this campus, it has administrative areas, youth housing areas, an outside recreation area, a kitchen and dining area (multipurpose room), educational classrooms, which were clean, well maintained and staffed accordingly; while operating orderly during the days of this visit. The PREA posters with the hot line number were displayed in each housing area and throughout the facility, appropriate staff to youth ratios of 1 to 12 were observed and shift supervisors were visible in the housing units and throughout the facility. There are 19 cameras installed throughout this facility that were being monitored by the main control center. The cameras were placed in areas where a youth might frequent and where a staff's supervision and monitoring of the youths could be augmented. The cameras in the housing units do not view into the shower and or in the toilet areas. It was strongly recommended that additional cameras, as funding becomes available, be placed in other areas throughout this facility i.e. closets, hallways, classrooms, Intake entry areas, utility rooms, additional cameras in the housing and education areas, etc. to cover the identified blind spots and to further augment staff supervision and monitoring. The facility had the PREA audit notices posted on colored paper throughout the facility and provided pictures of these posting prior to the on site visit. The 10 residents interviewed appeared to be well informed of their rights to be free from sexual abuse and sexual harassment, knowledgeable on how to report such incidents and their rights to be free from retaliation if they report a sexual abuse and sexual harassment allegation. They were not as knowledgeable as to the name of the outside victim intervention agency (Parkland Victim Intervention Services) that would provide emotional support and crisis counseling services related to sexual abuse if needed but they did reference that the name and number of the agency was posted in their housing unit. It was recommended that the Intake staff reinforce the name of the outside services available for a victim of sexual abuse. The 12 specialized staff members and the 10 random staff members and volunteer interviewed were knowledgeable regarding the facility's reporting procedures, the facility's PREA policy, were able to articulate the facility's protocol for collecting evidence, their first responder's duties and the procedures to be followed in a situation when they become knowledgeable of, suspect or are notified of a sexual abuse allegation including who conducts the sexual abuse investigations. A review of the files i.e. treatment, medical, etc. containing the required documentation occurred as well as being introduced to their client management database, TechShare, which is an enhanced version of Juvenile Case Management System (JCMS) provided more insight into their youth file maintenance and tracking. Overall, their preparation for this audit and their demonstrated continued practice of preventing, detecting and responding to sexual abuse, sexual harassment including staff neglect policy violation was evident. I also was introduced and did review the Electronic Medical Record (EMR) database in the clinic regarding how they document and track sick calls, hospital visits, etc. During the past 12 months the facility reported that there were two sexual harassment administrative investigative cases and zero sexual abuse cases. A review of these cases revealed that both were closed, 1 as Unfounded and 1Substantiated. There were zero criminal investigative cases alleging sexual abuse and sexual harassment during this reporting period.

Number of standards exceeded: 3

Number of standards met: 38

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.

Policy and Evidence reviewed: Zero Tolerance Policy, Organizational Chart, Agency Website and Interview with the PREA Coordinator.

Findings: A. The Lyle B. Medlock Residential Treatment Center has a written Zero Tolerance policy towards preventing, detecting and responding to all forms of sexual abuse and sexual harassment. The policy includes a description of how the agency responds to allegations of sexual abuse and sexual harassment as well as how they will go about reducing and preventing these incidents. This policy also has definitions that pertained to PREA. The PREA policy does have sanctions for youth, staff, volunteers and contractors who participate in the listed prohibited behaviors of sexual abuse, sexual harassment and policy violation. The facility's Zero Tolerance policy is posted on the agency's web site for review and there is a link further explaining PREA and Zero Tolerance. B. The facility has one dedicated PREA Coordinator reports to the Deputy Director of Executive and Adminstrative Service as indicated by the organizational chart provided reflecting this position and there is a PREA Compliance Manager assigned to this facility who works for her. The PREA Coordinator indicated that she has sufficient time to fulfill her PREA responsibilities during her interview and the PREA Compliance Manager indicated the same thus demonstrating compliance with this standard.

Corrective Action Findings: None

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.

Policy and Evidence reviewed: Zero Tolerance Policy, Sample Residential and Service Contracts and Interview with the Contract Specialist.

Findings: The Lyle B. Medlock Residential Treatment Center does include in all of their residential contracts to contracting residential facilities the PREA compliance language requirement which indicates that they will adopt and comply with the PREA standards. A. Sixteen contracts of residential providers were reviewed during the audit process for verification. The agency's Contract Administrator indicated during the interview that this language is included and is reviewed with each contractor prior to their annual contract renewal period. B. Monitoring the contracts for PREA compliance, according to the Contract Specialist during her interview, are conducted quarterly by her office and that each contracting agency are working independently towards their PREA compliance certification to be achieved by August 2016. A listing of contracting residential providers was also given to the auditor for review along with screenshots of the PREA Final Report of the three contracting residential providers that have already achieved PREA compliance thus demonstrating compliance with this standard.

Corrective Action Findings: None

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policies and Evidence reviewed: Zero Tolerance Policy, Staffing Plan, Budget and Schedules, Memorandum, Meeting minutes, Unannounced Rounds log, Dorm Log Book, Staffing Schedule and Youth Roster, Video Monitoring, Facility Administrator, PREA Coordinator, Intermediate and Higher Level, Random Staff and Youth Interviews.

Findings: The Lyle B. Medlock Residential Treatment Center policy requires the supervision and monitoring of the youth in the facility. Because there are two facilities on this campus whereas staff can work at either facility as circumstances necessitates. A. The daily average number of youth in this facility is 70 but the staffing plan is predicated on the average daily population total of 96 youths. B and C. The facility did provide documentation of their Staffing Plan, Staffing Plan Assessment, the facility's budget and meeting minutes during this audit that demonstrated compliance with this standard. The facility provided written evidence that at no time has the facility deviated from their staff–to-youth ratio of 1:12 during waking hours and 1:24 during sleeping hours, which is inclusive in their staffing plan. D. The facility did provide written evidence demonstrating that the PREA Coordinator, the Facility Administrator and members the agency's leadership review the staffing plan annually, which include video monitoring and their commitment to adherence to this plan. For fiscal year 2015-16 this plan did include the hiring of full time equivalents (FTEs) in a continuing effort to bring their staff -to-youth ratio to 1:8 during waking hours and 1:16 during sleeping hours by October of 2017. A budgeted spreadsheet for the FTEs for staffing this facility on each shift was provided as a sample. E. The facility did provide written evidence to demonostrate that the higher level supervisors are conducting unannounced rounds on all shifts reflecting. The facility's policy does indicates that disciplinary action will occurs if staff alert other staff of these unannounced rounds and during the random interviews of staff, especially with those JSO's working in the control center, articulated their awareness of this policy. During the visits to the housing units I observed the opposite gender staff utilized the knock and announce method to announce their presence before entering the dorm and both staff and youth articulate during their interviews that this practice is occurring especially during showering, restroom and changing routines thus demonstrating compliance with this standard.

Corrective Action Findings: None

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.

Policy and Evidence reviewed: Zero Tolerance Policy, Search Logs, Training Curriculum, Staff and Youth Interviews.

Findings: A and B. The Lyle B. Medlock Residential Treatment Center policy does prohibit cross gender viewing during rest room, changing clothes and shower routine and also prohibits cross gender pat, visual body and strip searches absence exigent circumstances. There were no cross gender pat, visual or strip searches conducted by medical personnel and or for an exigent circumstance during the last 12 months. C and E. A review of the search logs as well as excerpts extrapolated from the staff and youth interviews verified that this prohibited practice does not exist in this facility including searching or physically examining a Transgender or Intersex youth to determine their genitalia. There were no identified Transgender or Intersex youth in this facility at the time of this audit. The facility did provide written evidence demonstrating further that this practice is prohibit. D. The youth interviewed were able to definitively articulate that the female staff do knock and announce their presence before entering the opposite gender housing unit (dorm), that they are able to shower, use the restroom, dress and change clothing without being observed by the opposite gender and at no time have a staff of the opposite gender pat searched their person. A copy of the training curriculum on searches was provided and reviewed which also emphasized that all searches would be conducted professionally and in a respectful manner consistent with the security needs of the facility. The staff definitively articulated this practice during the interviews and this was also observed during the facility tour. F. The facility provided written training curriculum evidence to demonstrate that the staff were trained in cross gender pat searches including the training sign in rosters thus demonstrating compliance with this standard.

Corrective Action Findings: None

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.

Policy and Evidence reviewed: Zero Tolerance Policy, Intake and Orientation Documentation, Youth Handbook, Posters, Interpreter's Listing, Interpreter Claim Form and Staff Listing of Interpreters, Intake, Random Staff and Youth Interviews.

Findings: A. The Lyle B. Medlock Residential Treatment Center provided to the auditor the Zero Tolerance policy as well as written PREA material in English and Spanish i.e. brochures, etc. which the Intake staff provides to the youth during intake and orientation. B. The facility has a procedure in place for the acquistion of Interpreting and Translation Services through Dallas County for those youth who may be deaf, speech impaired, limited in English proficiency, blind and or low vision, or who are psychiatric or intellectually disabled. The facility provided the auditor with a copy of the procedure and Claim Form for these interpreting services for my review. They also provided the auditor with a listing of the facility staff utilized as interpreters for Limited English (Spanish) speaking youth and for those of Vietnemese decent as applicable. During the interview with a Limited English youth, the facility did provide a staff person to interpret the interview questions and responses from the youth to further demonstrate their compliance with this standard. The facility indicated that there were no other interpreting services required in the last 12 months. C. The facility's policy states that they do not utilizing youth interpreters, youth assistants or youth readers for any PREA-related activity in this facility. The facility did provide a copy of the Youth Orientation manual in Spanish for those youth who are of Spanish decent or who limited in English proficiency, even though an interpreter would be provided thus demonstrating compliance with this standard.

Corrective Action Findings: None.

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.

Policy and Evidence reviewed: Zero Tolerance Policy, Volunteer and Contractor Policy and Agreements, Criminal Records and Child Abuse Registry Check Documentation, Training Records and Interview with the Human Resource Specialist.

Findings: A. The Lyle B. Medlock Residential Treatment Center policy does considers any incident of sexual abuse and sexual harassment in determining whether to hire, promote or enlist the services of contractors who have contact with the youth. The policy states that providing false information will be grounds for termination for omitting information of misconduct and it also provides that a former employee's misconduct would be provided to another agency for substantiated findings of sexual abuse and sexual harassment. B. Regarding volunteers and contractors, the policy states that their services will be terminated and the finding, as it pertains to a contractor will be reported to their licensing authority. During the interview with the Human Resource Specialist revealed that the agency does conducts criminal background checks and child abuse registry checks prior to hiring and promotions. C, D and E. The facility did provide written evidence demonstrating that they did conduct background checks and child abuse registry checks on all of their current employees, volunteers and contractors during the last 12 months which are also performed every two years by the agency and twice within five years exceeding the standard. F. The facility did provide written evidence on the employees self reporting requirements and that omissions regarding misconduct shall be grounds for termination. The facility did provide a sample reference check forms that staff, volunteers and contractors complete for the background checks. The facility did provide documented evidence to support that 100% of their staff, volunteers and contractors have had background and child abuse registry checks performed during the last 12 months. There were 12 new hires during this reporting period and 5 service contractors whereas background and child abuse registry checks were conducted thus demonstrating compliance with this standard.

Corrective Action Findings: None

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.

Policy and Evidence reviewed: Zero Tolerance Policy, Facility Schematics reflecting the camera locations and viewing of Control Room/Facility cameras.

Findings: A. The Lyle B. Medlock Residential Treatment Center has not made any modifications to or any renovations in this facility as of August 20, of 2012 and they currently have 19 cameras throughout the facility to augment the staff's supervision and monitoring of the youth. B. It was recommended by this auditor that if funding becomes available that additional cameras be purchased for placement in the identified blind spots in the youth dorms, classrooms, and other identified areas throughout the facility to further augment the staff's supervision, monitoring and in the prevention, detection and response to sexual abuse and sexual harassment allegations further demonstrating compliance with this standard.

Corrective Action Findings: None

Standard 115.321 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence reviewed: Zero Tolerance Policy, Memorandum on Dallas County Sheriff Department, Parkland Hospital's Victim Intervention Program Memorandum, Medical and Mental Health staff, and PREA Coordinator's Interview.

Findings: A. The Lyle B. Medlock Residential Treatment Center policy outlines their protocol for conducting investigations of sexual abuse and sexual harassment as well as requesting information from the respective external investigative entities, as applicable, on the progress of each investigation. B. The facility provided a copy of and stated that they follow the National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescents 2013 for obtaining usable evidence for administrative and criminal investigations. The facility is responsible for conducting administrative investigations for the agency and the Dallas County Sheriff is responsible for conducting criminal investigations of sexual abuse. C. The Parkland Health and Hospital System is where a youth would receive routine and emergency medical care including where they would also be taken by local law enforcement in the event a forensic examination (SANE) for sexual abuse incident is required. D. The facility did provide written evidence demonstrating that they have obtained emotional support and crisis counseling services from the Parkland Victim Intervention Program, if and when needed. In the last 12 months the facility indicated that there have been no SANE examinations required which was also confirmed by the medical personnel interviewed including the medical file review. E. The facility indicated and demonstrated by employee roster that they do have a qualified staff members available to serve as an advocate if needed, for a victim of sexual abuse. F. The facility did provide written evidence requesting that the Dallas County Sheriff Department will follow the requirements of the National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescents 2013 for obtaining usable evidence for criminal investigations of which they indicated that they would thus demonstrating compliance with this standard.

Corrective Action Findings: None

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence reviewed: Zero Tolerance Policy, Incident Reports, Copies of Administrative Investigative Cases, Agency Website, and the Investigator's Interview.

Findings: A and B. The Lyle B. Medlock Residential Treatment Center policies requires that all allegations of sexual abuse and sexual harassment are to be reported to the Facility Administrator and to be investigated. It further describes that the Internal Investigators and the Texas Juvenile Justice Department (TJJD) are charged with conducting the administrative investigations and that the Dallas County Sheriff Department will conduct all criminal investigations referred to them. The facility did provide the auditor with a copy of their Incident Report that is shared with the Dallas County Sheriff Department and the Texas Juvenile Justice Department in the event of an Administrative and or

Criminal investigation. The facility reported 2 allegations of sexual harassment that resulted in administrative investigations and zero sexual abuse allegations during the last 12 months and zero allegations of sexual abuse and sexual harassment resulting in a criminal investigation. One of the administrative investigation for sexual harassment was closed as an Unfounded finding and the other was closed as a Substantiated finding. The auditor did review and observe on the agency's website that facility does have their internal administrative investigation policy posted for review as required thus demonstrating compliance with this standard.

Corrective Action Findings: None.

Standard 115.331 Employee training

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

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

Policy and Evidence reviewed: Zero Tolerance Policy, Training Curriculums, Staff Training Rosters, Training Certificates, Random Staff and PREA Coordinator Interviews, and review of dorm log book for searches.

Findings: A. The Lyle B. Medlock Residential Treatment Center policy requires that the facility provide PREA related training to all its employees who may have contact with youth. The agency did provide written evidence demonstrating the various PREA training provided to the staff i.e. training curriculums on LGBTI, communication boundaries, trauma informed care, etc. The facility did also provide the training curriculum for the cross gender pat down search training as required for all of their security staff. B. The PREA Coordinator did indicate during her interview that their PREA Refresher training occurs annually and the certification training for JSO's which also includes PREA, occurs every two years. C. The facility indicated that the number of facility staff trained during the last 12 months were 70 with 100% of them being trained. During the the staff interviews they were able to articulate the coverage of the required elements of of this standard (a) (1-11), and (b) which were being met through the new hire orientation/training and through on the job training and refresher training session. The staff seemed well versed and trained in the areas of PREA regarding their reporting duties, they were knowledgeable of their first responder responsibilities and what individuals and or entity conducts the administrative and or criminal investigations. D. The facility did provide written evidence in the form of trainee sign in sheets with the course title and descriptions for each training class for the auditor's review. The PREA Coordinator did indicated during her interview that they also provide Trauma Informed Care, Abuse, Neglect and Exploitation training and referesher training to all of the facility staff annually thus demonstrating compliance with this standard.

Corrective Action Findings: None.

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.

Policy and Evidence reviewed: Zero Tolerance Policy, PREA Questionnaire, Volunteer and Contractor's Training Curriculum and Acknowledgement Form, PREA Coordinator, Volunteer, Contractor's Interviews.

Findings: A. The Lyle B. Medlock Residential Treatment Center policy do require that all volunteers and contractors who have direct access to youth are notified and trained on understanding their reporting responsibilities regarding PREA. B. The facility did provide written evidence of the PREA curriculum utilized for their volunteers and contractors and did provide written training sign in and acknowledgment forms to demonstrate their compliance with this standard. C. The facility dd also provide written evidence demonstrating that the number of volunteers and contractors trained in PREA during the last 12 months were 5 thus verifying that 100% of them were trained as indicated in the PREA Questionnaire. The volunteer interviewed indicated that she received the PREA training, discussed how informative it was to her and what her reporting responsibilities are if an alleged sexual abuse and sexual harassment allegation is made to her thus demonstrating compliance with this standard.

Corrective Action Findings: None.

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.

Policy and Evidence reviewed: Zero Tolerance Policy, Youth Intake and Orientation Manual, PREA Video, Brochures, etc. , Tech Share Client Management Database, Admitted and Educated Youth Documentation, Interpreting Claim Form Request, Retaliation Log review, Random Staff, Mental Health Specialist and Youth Interviews.

Findings: A. The Lyle B. Medlock Residential Treatment Center does provide the youth with an orientation packet of information in English and in Spanish upon Intake, that they do watch the Safeguarding Your Sexual Safety PREA video as part of the comprehensive education and are given additional PREA brochures and other information i.e. hotline number, phone location, etc. during this time. The policy does indicate that this information will be provided to the youth will be in an age appropriate manner as demonstrated in the Youth Orientation Manual which was also translated into Spanish. A review of this material verified that this standard is being met. The date and time of the youth's intake, orientation and when this information is provided is documented in the youth's file through TechShare, which is their client management database, as reviewed by the auditor. B. The comprehensive education does occurrs within 10 days of a youth's Intake. C. The facility admitted and educated 129 youth from the 129 youth who came into Intake during the last 12 months. D and E. The facility did provide a written evidence demonstrating that Dallas County will provide services to those youth who are hearing, vision impaired, psychiatric and disabled; that the teachers from the Academy for Academic Excellence, their charter school, and the designated facility staff will provide assistance for those youth who are intellectually, psychiatric disabled and limited in English proficiency. F. During the facility tour random interviews were conducted of the youth and they acknowledged receiving the PREA information during the Intake and Orientation process, acknowledged that they watched the Safeguarding Your Sexual Safety PREA video, which the facility shows every youth during the Orientation process and were able to articulate their knowledge regarding PREA, reporting of allegations of sexual abuse and sexual harassment and how that they have a right to be free from retaliation. The Zero Tolerance policy, PREA related posters, brochures with the hot line numbers for reporting incidents of sexual abuse and sexual harassment and the victim intervention program were all prominently displayed throughout the facility thus demonstrating compliance with this standard.

Corrective Action Findings: None.

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.

Policy and Evidence reviewed: Zero Tolerance Policy, Investigator's Training Curriculum, Internal Investigator's Specialized Training Roster and the Investigator's Interview.

Findings: A. The Lyle B. Medlock Residential Treatment Center policy does indicate that they and the Texas Juvenile Justice Department (TJJD) are the entities, as applicable, that will conduct their administrative investigations and that the Dallas County Sheriff Department is the outside law enforcement entity who conducts the criminal investigations for sexual abuse and sexual harassment allegations. B. The facility's internal investigator indicated during his interview that he has received the specialized investigator's training, interview training, training on Miranda and Garrity warning, evidence collection, etc. to assist him in conducting sexual abuse and sexual harassment investigations even though criminal investigations will be referred to outside law enforcement. C. The PREA Coordinator did provide copies of their investigator's training records that reflected receipt of their specialized interviewing training when conducting sexual abuse investigations which was corroborated during the investigator's interview thus demonstrating compliance with this standard.

Corrective Action Findings: None

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.

Policy and Evidence reviewed: Zero Tolerance Policy, Hospital Contract/Agreement, PREA Training Roster, Specialized Training Certificates for Medical and Mental Practitioners, Medical and Mental Health Staff Interviews.

Findings: A. The Lyle B. Medlock Residential Treatment Center policy states that they do not conduct forensic medical exams on a youth for sexual abuse but if applicable, they will refer the alleged victim to the Parkland Health and Hospital System where the examination would occur free of charge to the youth. B. The medical staff in this facility indicated that by policy and practice, during the interview, that they do no conduct SANE examination nor has the Parkland Health and Hospital System had a referral from them to conduct a SANE examination for this facility in the last 12 months. C. All of the medical and mental health personnel at the facility indicated during their interview that they have received specialized training in PREA and did provide certificates of their specialized training received thus demonstrating compliance with this standard.

Corrective Action Findings: None

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence reviewed: Zero Tolerance Policy, Tech Share Client Management Database, Electronic and Hard Copy of the Behavioral Screening Instrument and Instructions Form, Intake Staff Interview, Youth Interviews, and the PREA Coordinator's Interview.

Findings: A. The Lyle B. Medlock Residential Treatment Center policy does outline that the screening of youth during intake must occur within 72 hours of adminssion. B, C and D. The screening instrument, which is in their client management database called TechShare, that is automated, contains all of the eleven screening elements (1-11) required of this standard and contains questions which covers the youth own perception of vulnerability as well as any observations of the intake staff regarding a youth's gender non-conforming or perceived vulnerable appearance. The Intake staff indicate during their interview that also have a process, in accordance with policy, for the re-assessment of a youth and a hard copy of this form was provided for the auditor's review. E. During the intake staff interviews they indicated that information obtained by them during the initial screening i.e. sensitive information, has limited dissemination to prevent exploitation to the detriment to the youth, that appropriate controls are in place, that it is password protected and that policy indicates who have access to it. Furthermore, a review of the documentation provided during the pre-audit and on site documentation review process further demonstrated compliance with this standard.

Corrective Action Findings: None.

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence reviewed: Zero Tolerance Policy, Protective Isolation Policy, Classification Plan Policy, Seclusion Logs, Intake Officer Interview, Behavioral Screening Instrument and Instruction, and the Mental Health Specialist interview.

Findings: A. The Lyle B. Medlock Residential Treatment Center Zero Tolerance and Protective Isolation policy was provided to the auditor on the usage of the screening information. The facility's Intake staff was able to demonstrate how the screening instrument is used to make informed housing assignments which is discussed weekly during their multidisciplinary meetings. B. The facility policy does prohibit the placement of youth in isolation due to risk of sexual victimization and they did provide written evidence demonstrating that seclusion (isolation) has not been used for sexual abuse and or sexual harassment victims and or perpetrators in the last 12 months, which was corroborated during the interview with the Mental Health Specialist. C and D. A copy of the Behavior Screening form was provided to the auditor for review and he was informed by the Intake Staff that housing assignments are not based on LGBTGNC status, perceived status or identification status as an indicator of likelihood of being sexually abusive. This facility did not have any identified Transgender or Intersex youth in their population during this on site audit. E, F and G. The facility policy does allow, when applicable for an Intersex and Transgender youth to shower separately and to be reassessed twice a year to review any threats to safety experienced by the youth with serious considerations being given with respect to her safety as applicable. H and I. During the last 12 months the facility provided documented evidence and reported that there were zero youth placed in isolation as a result of their risk to sexual victimization, that zero youth were denied daily access to services and that the average time of a youth being in isolation for a risk to sexual victimization was zero

thus demonstrating compliance with this standard.

Corrective Action Findings: None.

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.

Policy and Evidence reviewed: Zero Tolerance, Incident Report and Grievance Policies, Facility Memorandum on Civil Immigration, PREA Posters, Hotline Numbers, PREA Coordinator, Random Staff and Youth Interviews, and the Third Party Reporting Policy.

Findings: A. The Lyle B. Medlock Residential Treatment Center policy does provides multiple internal ways (i.e. sick call, grievance, trusting adult) and several external numbers for a youth to privately report allegations of sexual abuse and sexual harassment. B. One such number for reporting an allegation is to the Texas Juvenile Justice Department's 1-877-STOP-ANE which is a toll free number posted on each housing units and throughout the facility as observed during the facility tour. C. Interviews conducted with the facility's staff and youth demonstrated their knowledge of, unimpeded access to and the facility's staff compliance with this standard including that they do accept, document and immediately report all verbal reports of sexual abuse and sexual harassment from a youth to the appropriate upper level supervisory and or administrative staff. D. The youth are provided with a grievance form from staff without question according to policy as one tool for reporting an allegation. E. The staff and youth during their interviews also informed the auditor that they can report a sexual abuse and sexual harassment allegations privately, confidentially, anonymously and or through a 3rd party. The staff can use the same 1-877-STOP-ANE number for making such reports or can privately report it to their supervisor. The facility's Zero Tolerance policy states that they do not detain youth solely for civil immigration purposes and the facility provided written evidence corroborating that this has not occurred thus demonstrating compliance with this standard.

Corrective Action Findings: None

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.

Policy and Evidence reviewed: Zero Tolerance Policy, Retaliation Monitoring Form, Grievance Policy and Logs, Memorandum on Exhaustion of Administrative Remedies, applicable Investigation Case Log and cases that exceeded 90 days or Required an Extension of 70 days, Disciplinary Action Records for Bad Faith filings as applicable, Youth Handbook, Investigator's, Random Staff and Youth Interviews.

Findings: A, B and C. The Lyle B. Medlock Residential Treatment Center Grievance policy imposes no time limit regarding filing an

allegation for sexual abuse, it also states that a youth cannot resolve a sexual abuse grievance with the alleged staff person informally, and that it will not be referred to the alleged staff member for resolution. D. The facility policy does state that it shall issue a final decision within 30 days of the initial filing. E. The facility's policy does state that a 3rd party can file a grievance on behalf of a youth. The facility's policy does state that a youth will be monitored for retaliation up to 90 days or until the investigation is closed or is Unfounded. F. The PREA Coordinator showed the auditor the grievance lock boxes where a youth could file their grievance during the facility tour and provided him with a copy of the Youth Handbook that describes the youth the grievance procedure including the filing of emergency grievances. G. The facility's policy does state that disciplinary action can be taken against a youth if a grievance is filed in bad faith. The facility did provide written evidence demonstrating that there were zero grievances filed in the last 12 months for sexual abuse and sexual harassment, that zero emergency grievances filed in the last 12 months, and that there were zero sexual abuse and sexual harassment grievances and or administrative/criminal investigations that were not completed within 90 days or that required extensions up to 70 days in the last 12 months thus demonstrating compliance with this standard.

Corrective Action Findings: None

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence reviewed: Zero Tolerance and Visitation Policies, Parkland Victim Intervention Services Memorandum, Youth Handbook, PREA Posters and other PREA-related documentation, Facility's Schematics of Visitation Area, Random Staff, Youth and PREA Coordinator Interviews.

Findings: A. The Lyle B. Medlock Residential Treatment Center policy does outline how a youth would have access to outside confidential support services and legal representation. The facility do provide the youth with information regarding their access to outside and other services, visitation, 3rd party reporting, 1-877-STOP ANE hotline information their during Intake and Orientation session. They are also provide a copy of the Youth Handbook which contains the toll free and or local phone numbers for PREA allegation reporting and related and service. B and C. The facility did provide written evidence from Parkland Victim Intervention Services for the provision of emotional support and crisis counseling services as needed for victims of sexual abuse. The youth interviewed could recall being given this information on outside support services during the Orientation process with some having this knowledge from a previous placement, they articulated that that they could communicate with outside service providers privately and that this conversation would be confidential. D. The facility does provide the youths with reasonable and confidential access to their parents, legal guardians and lawyers for visitation, as indicated during the staff and youth interviews, and the identified visitation space was reflected on the facility schematics thus demonstrating compliance with this standard.

Corrective Action Findings: None

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.

Policy and Evidence reviewed: Zero Tolerance, Grievance and Third Party Reporting Policies, Agency Website, Random Staff and Youth Interviews, Copy of the Youth Grievance Form, and the PREA Coordinator's Interview.

Findings: A. The Lyle B. Medlock Residential Treatment Center policy does establishe the method outlined to receive a 3rd party reports of sexual abuse and sexual harassment on behalf of a youth and that this information is also available on the Dallas County County Juvenile Probation's website. The facility did provide written evidence for the link to this website which was visited by the auditor for review. The facility did also provide written evidence demonstrating how they receive the 3rd party report for sexual abuse and sexual harassment, and provided the auditor with a copy of the Parent brochure on PREA in English and in Spanish, which is mailed to them. This policy and practice was corroborated during the PREA Coordinator, Random Staff and Youth interviews thus demonstrating compliance with this standard.

Corrective Action Findings: None

Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence reviewed: Zero Tolerance Policy, Parkland Victim Intervention Services Memorandum, Intake Officer, Medical and Mental Health Practitioners, Facility Administrator, PREA Coordinator, PREA Compliance Manager and Random Staff Interviews, Referral Form to Outside Law Enforcement Investigative Entity, and the First Responder Interviews.

Findings: A. The Lyle B. Medlock Residential Treatment Center policy requires that all staff to immediately report to the Facility Superintendent any suspicion, knowledge, or information of a allegation of sexual abuse, sexual harassment, retaliation and staff policy violation for neglect of their responsibilities that may have contributed to the incident or retaliation, including 3rd party reports. The facility also provided other related policies regarding their internal processes, personnel action and the first responders responsibilities and duties of the staff including referrals to be made to the Parkland Victim Intervention Services program for mental health assessment and treatment as necessary. B and D. The facility's policy do state that all staff are mandatory reporters which was also corroborated during the random staff interviews. The agency's policy does indicate and direct the facility staff including medical and mental health personnel as mandatory reporters of child abuse, to immediately report the alleged information, complete a serious incident report and forward it to the Facility Superintendent. C. The facility's policy does prohibits the staff from revealing any information related to the sexual abuse and sexual harassment allegation to anyone other than to the extent necessary which was also corroborated during the random staff and first responder interviews. E and F. The Facility Superintendent or designee then reports the allegation to their Internal Investigators, Texas Juvenile Justice Department and to the Dallas County Sheriff Department as appropriate and applicable. During the staff interviews they demonstrated their knowledge regarding their reporting responsibilities including notification to their immediate supervisor, the Facility Superintendent, to local law enforcement (Dallas County Sheriff Department), to the internal investigators, to the alleged victim's parent, legal guardian, lawyers and to the court of jurisdiction if applicable thus demonstrating compliance with this standard.

Corrective Action Findings: None

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence reviewed: Zero Tolerance and Isolation Policies, Seclusion Log, Memorandum on the Agency's Protection Duties, Facility Administrator and Random Staff Interviews.

Findings: A. The Lyle B. Medlock Residential Treatment Center policy does outline their internal processes regarding the agency's protection duties when informed that a youth is subject to a substantial risk of imminent sexual abuse. During the specialized and random staff interviews they articulated their knowledge of these protections and that no youth had been placed in isolation for a substantial risk of sexual abuse. The facility also provided written evidence i.e. Seclusion Logs which indicated that they had zero youth in isolation during the last 12 months who were subject to any type of substantial risk of imminent sexual abuse while in their facility thus demonstrating compliance with this standard.

Corrective Action Findings: None

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence reviewed: Zero Tolerance Policy, Allegation Notification to Other Facilities, Facility Administrator, PREA Coordinator, Intake Officer and Internal investigator's Interviews, Investigative Administrative and or Criminal Case review.

Findings: A. and B The Lyle B. Medlock Residential Treatment Center policy does outline the staff's requirement of reporting to other confinement facilities within 72 hour of being informed during Intake of an allegation being made by a youth of sexual abuse and sexual harassment and that it will be documented in the youth's electronic file (TechShare). The interview conducted with the Intake staff as well as with other specialized staff demonstrated their knowledge and understanding of this reporting requirement and need for policy adherence. C. The facility had documented zero reported cases of reporting to another confinement facility an allegation of sexual abuse that occurred within the past 12 months which was corroborated by the PREA Coordinator and the Facility Superintendent during their interviews. During the random staff interviews they were able to articulate the notification protocol for reporting to other confinement facilities. D. The facility during the last 12 months did not receive an allegation of a sexual abuse incident occurring at another facility but in their policy it states that if one did occur notification would be made within 72 hours and that they would ensure that an investigation would occur thus demonstrating compliance with this standard.

Corrective Action Findings: None.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence reviewed: Zero Tolerance Policy, Memorandum on First responder Duties, First Responder, Non-Security Staff, Random Staff, PREA Compliance Manager and PREA Coordinator Interviews, and a review of the Investigative Cases.

Findings: A and B. The Lyle B. Medlock Residential Treatment Center has established a policy that outlines the first responder duties for responding to sexual abuse and sexual harassment allegations. The facility reported there were 2 allegation of sexual harassment and zero allegations of sexual abuse, whereas in those instances the collection of evidence, which was not applicable, but would have been collected in the appropriate time frame, but none was required. Furthermore, that there was zero times that the crime scene and or evidence needed to be preserved, zero times it was requested of a victim not to take any action, zero times it requested of the abuser not to take action, zero times that non-security staff had to respond, and that in both instances was the security staff notified and responded to the allegation. All of the random and specialized staff interviewed were able to articulate their knowledge, understanding, responsibilities and duties as a first responder including informing the victim and the abuser not to destroy evidence by washing, eating, changing clothes, drinking, defecating or brushing teeth. The facility had reported 2 allegations of sexual harassment with 1 being Unfounded and 1 being Substanitated, zero sexual abuse allegations were made during the past 12 months and that the first responders acted in accordance with the agency's policy and the facility's protocol for the two reported allegations thus demonstrating compliance with this standard.

Corrective Action Findings: None.

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.

Policy and Evidence reviewed: Zero Tolerance Policy, Copy of Facility's Written Plan for Coordinated Response Plan to Sexual Abuse Allegation, Sexual Abuse Review Team Member and PREA Coordinator's Interview.

Findings: A. The Lyle B. Medlock Residential Treatment Center policy does outline the procedure for specific staff's response to allegations of sexual abuse and sexual harassment in the facility. The facility policy, as corroborateded by the interviews with a member of the Sexual Abuse Review Team and the PREA Coordinator that they understood the process for reporting a sexual abuse and sexual harassment allegations, the responsibilities of the facility administrator, supervisor/manager on duty, medical and mental health personnel, the investigator and the responsibility of a first responders thus demonstrating compliance with this standard.

Corrective Action Findings: None.

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.

Policy and Evidence reviewed: Zero Tolerance and Human Resource Policies, PREA Coordinator and Human Resource Specialist Interviews.

Findings: A and B. The Lyle B. Medlock Residential Treatment Center Human Resource policy states that they do not enter into collective bargaining agreements and the facility's policy allow for an alleged staff abuser to be removed from contact with a youth pending an investigation or of a determination of whether and what extent discipline is warranted thus demonstrating compliance with this standard.

Corrective Action Findings: None.

Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence reviewed: Zero Tolerance and Retaliation Policies, Internal Investigator's Interview, Protective Against Retaliation Policyand Monitoring Forms, Parkland Victim Intervention Services Program Memorandum and interviews with the PREA Coordinator and mental Health Specialist.

Findings: A. The Lyle B. Medlock Residential Treatment Center policy does outline their response to retaliation and the protection for all youth and staff members who report an allegation of sexual abuse and sexual harassment and or who cooperates with an investigation. The facility has designated specific staff who are responsible for monitoring youth and staff against retaliation for reporting a sexual abuse and sexual harassment allegation. B. The facility's policy does state that they employ multiple protective measures to protect a youth from changing housing assignments, removing them from the facility to another, removing the abuser or alleged staff member from contact with the victim, including providing emotional support to the victim. C and D. The facility's policy states that a youth's conduct would be monitored up to 90 days against retaliation, including periodic status checks, that they would promptly remedy any such retaliation, and will provide treatment services as needed. E. The facility's policy states that they will protect any other individual who cooperates with an investigation who may express fear of retaliation also. F. The facility's obligation to monitor shall terminate if the allegation is determined to be Unfounded. The facility reported zero times where protective measures were required to protect staff and or youth against retaliation in the last 12 months thus demonstrating compliance with this standard.

Corrective Action Findings: None.

Standard 115.368 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence reviewed: Zero Tolerance and Isolation Policies, Memorandum on Post Allegation Protective Custody, Seclusion Logs, Random Staff, Facility Administrator, PREA Compliance Manager and PREA Coordinator Interviews.

Findings: A. The Lyle B. Medlock Residential Treatment Center policy does state the prohibition of the use of segregation and or seclusion housing to protect a youth who have alleged sexual abuse and sexual harassment. The facility did provide written evidence demonstrating that there were zero youths who were held in isolation (seclusion) who alleged sexual abuse and sexual harassment or who suffered sexual abuse in the last 12 months. The facility's PREA Coordinator, PREA Compliance Manager and the Facility Superintendent stated during their interviews that they do not use seclusion to protect a youth from sexual abuse or sexual harassment thus demonstrating compliance with this standard.

Corrective Action Findings: None.

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence reviewed: Zero Tolerance and Investigative Policies, Internal Investigator Interviews, Investigator's Training Record, Administrative Investigative Case, PREA Compliance Manager, and the PREA Coordinator Interviews.

Findings: A. The Lyle B. Medlock Residential Treatment Center policy does outline that they and the Texas Juvenile Justice Department (TJJD) conduct all administrative investigations and that the Dallas County Sheriff Department will conduct all criminal investigations of sexual abuse and sexual harassment. B. The facility did provide written evidence of their investigators training records to corroborate this policy. C. The facility's Investigators described during the interview his gathering process i.e. evidence, videos, interviews, etc. and review of prior complaints and reports of sexual abuse of the alleged perpetrator when conducting an investigation. The facility did provide written evidence of 2 cases where sexual harassment had occurred and was investigated in this facility, zero sexual abuse cases, and zero cases where sexual abuse and sexual harassment had occurred in another facility, which would had been investigated by the appropriate entities. D and F. The facility reported that 2 sexual harassment cases were closed in accordance with facility's policy. G, H, I and J. The facility also reported that there were zero substantiated investigative cases that had been referred for prosecution and that if it had been referred that they would retain these case files as long as the abuser is incarcerated or as long as the staff was employed, 5 years plus according to their policy and applicable law. K. The facility's policy states that an employee's termination or the departure of the victim and or perpetrator's being out of the control of the facility shall not cause the investigation to be terminate and that polygraphs are not utilized. M. During the investigator's interview he described how they remain in contact with the outside investigative entities as applicable thus demonstrating

compliance with this standard.

Corrective Action Findings: None.

Standard 115.372 Evidentiary standard for administrative investigations

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

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

Policy and Evidence reviewed: Zero Tolerance Policy, Investigation Policy, the Investigator, Facility Administrator and PREA Coordinator's Interview.

Findings: A. The Lyle B. Medlock Residential Treatment Center policy does state that the standard used for proof when determining substantiation of an allegation for sexual abuse and sexual harassment in an administrative investigations is the preponderance of evidence.

Corrective Action Findings: None.

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 and Evidence reviewed: Zero Tolerance Policy, Youth PREA Notification Form, Administrative Investigative Cases and the Investigator's Interview.

Findings: A and B. The Lyle B. Medlock Residential Treatment Center policy does outline the facility's responsibility in notifying a youth regarding the initiation and the outcome of an administrative and or criminal investigation for sexual abuse. C and D. The facility's policy also outlines the notification process for a staff on youth allegation and a youth on youth allegation. The facility has reported zero sexual abuse and two sexual harassment allegations during the past 12 months, provided documentation that they had informed the youth of the outcomes, and that these investigation was completed by Dallas County Internal Investigator. E. The facility did provide written evidence verifying that notification had been given to the youth during the initial of and at the conclusion of an the investigation, whether it was a youth on youth or staff on youth and a sample copy of that notification form was provided. There were zero notifications made and documented because there were zero sexual abuse allegations reported. This auditor recommended to the facility as a "best practice" that they notify the youth when an administrative investigation is initiated and concluded for sexual harassment. The facility also reported that there have not been any indictments, any referrals for prosecution or convictions of a abuser for sexual abuse and sexual harassment in the last 12 months thus demonstrating compliance with this standard.

Corrective Action Findings: None

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence reviewed: Zero Tolerance and Human Resource Policy, Memorandum on Disciplinary Sanctions for Staff, Disciplinary Action Letter (if applicable), Referrals to Law Enforcement Entity Documentation, and Human Resource Specialist Interview.

Findings: A and C. The Lyle B. Medlock Residential Treatment Center policy does outline the steps to be taken to discipline a staff for sexual abuse and sexual harassment and that sanctions for this violation will be commensurate with the nature and circumstances of the act committed. B. The facility reported and provided written evidence demonstrating that there have not been any staff disciplinary actions taken during the past 12 months due a to violation of the agency's policy of sexual abuse and sexual harassment and that termination would be the presumptive disciplinary sanction. D. The facility reported that zero referrals were made to a law enforcement or relevant licensing entity for sexual abuse and sexual harassment allegations in the last 12 months thus demonstrating compliance with this standard.

Corrective Action Findings: None

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence reviewed: Zero Tolerance, Volunteer and Contractor's Policies, Volunteer and Contractor's Disciplinary Letter (if applicable), Memorandum on Corrective Action for Volunteers and Contractors, Referral to Local Law Enforcement and Licensing Entity (if applicable), Facility Administrator, PREA Compliance Manager and PREA Coordinator Interviews.

Findings: A. The Lyle B. Medlock Residential Treatment Center policy does prohibits volunteers and contractors from contact with youths who have engaged in sexual abuse and outlines the steps to be taken when disciplining volunteers and contractors for sexual abuse and sexual harassment violations. B. The facility has reported and provide written evidence that there were zero cases where a volunteer and or a contractor received disciplinary action during the past 12 months due to violation of the agency's policy of sexual abuse and sexual harassment. The facility also provided written evidence that there were zero reports made to local law enforcement or to a relevant licensing body for a contractor or volunteer engaging in sexual abuse with a youth thus demonstrating compliance with this standard.

Corrective Action Findings: None.

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 and Evidence reviewed: Zero Tolerance and Isolation Policies, Administrative Investigative Cases, Youth Handbook, Intake Staff, PREA Coordinator and Facility Administrator's Interviews.

Findings: A. The Lyle B. Medlock Residential Treatment Center policy does prohibits denying a youth large muscle exercise, daily visits. educational programming, and access to other programs as a disciplinary sanction for engaging in sexual abuse; it outlines the process for taking disciplinary action against a youth when they participate in sexual misconduct with another youth, staff, volunteer or contractor in the facility. B and E. The policy outlines the formal due process hearing that must occur following an administrative finding whereas the sanctions are to be commensurate with the nature and circumstances of the abuse committed including when a finding of sexual contact with a staff proves that they did not consent to such contact. C and D. The disciplinary process, according to their policy includes if the youth's mental disabilities and mental illness contributed to the behavior when determining sanctions and if therapy, counseling or other interventions shall be considered for the youth to participate in. F. The facility's policy states that they do not impose disciplinary sanctions if a youth makes a report of sexual abuse and sexual harassment in good faith. G. The facility reported 2 administrative findings of a youth on youth sexual harassment which was Unfounded and the other was Substantiated, zero criminal findings of a youth on youth sexual abuse and sexual harassment and zero instances where disciplinary sanctions was imposed for a sexual abuse and sexual harassment for a substantiated allegation. The facility's Zero Tolerance policy prohibits all forms sexual abuse, sexual harassment and sexual misconduct in the facility. During this reporting period the facility reported that zero youths were placed in isolation as a disciplinary sanction for a youth on youth sexual abuse and sexual harassment allegation in the past 12 months thus demonstrating compliance with this standard.

Corrective Action Findings: None.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence reviewed: Zero Tolerance Policy, Mental and Medical Screening Instrument Form, TechShare Client Management Database Review, Electronic Medical Records Database, Prior Sexual Victimization Referral Forms and or Listing (as applicable), Youth Mental Health Files and Follow Up Documentation, Medical, Mental Health Practitioners, PREA Compliance Manager, PREA Coordinator and Random Staff Interviews, and Facility's Schematics for Medical Clinic.

Findings: A. The Lyle B. Medlock Residential Treatment Center policy does outlines the procedure to follow for medical and mental health screenings consisting of the youth's history of sexual abuse, if applicable. The medical and mental health staff interviewed stated that

electronic files containing some of this information is not accessible to non-treatment staff. B. The facility did not identify any youth who had disclosed a prior sexual victimizations in the past 12 months which occurred either at another confinement facility or in a community setting, and their policy does indicate that medical and mental health follow up assessments would be offered to these and other youths within 14 days of Intake and or when prior sexual victimization was alleged to have occurred. C. The medical and mental health staff stated during their interviews that they do maintain secondary information in their treatment files, which are kept in an office under lock and key whereas only they have access to them. The facility's Zero Tolerance policy states that all staff are considered mandatory reporters of child abuse according to their State law which include medical and mental health practitioners. D. The facility's policy states how informed consent is to be obtained from a youth, unless they are under the age of 18, when sexual abuse did not occur in an institutional setting thus demonstrating compliance with this standard.

Corrective Action Findings: None.

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence reviewed: Zero Tolerance Policy, Memorandum on Access to Emergency Medical and Mental Health Care, Medical and Mental Health Practitioners Interviews, Youth Medical and Mental Health Files and Elelctronic Medical Record review.

A. The Lyle B. Medlock Residential Treatment Center reported that there were zero cases of sexual abuse requiring medical attention at this facility during the past 12 months and that the facility's policy outline how a youth will have access to these emergency services in a timely, unimpeded manner. B and C. The policy indicates if no qualified medical or mental health practitioner is on duty what the first responders responsibilities are to protect the victim, notify the appropriate on call medical and mental health practitioner, and that the victim is offered timely information and access to emergency contraceptions and STI prophylaxis. D. The facility did provide written evidence demonstrating that access to emergency medical and mental health services would be provided at the Parkland Health and Hospital System and that these treatment services shall be provided at no cost to the victim whether they name the abuser or cooperates with the investigation. There were zero sexual abuse cases to review that required a youth emergency access to medical and mental health services in the last 12 months according to the medical staff during his interview thus demonstrating compliance with this standard.

Corrective Action Findings: None

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence reviewed: Zero Tolerance and Medical and Mental Health Treatment Policies, Memorandum on Ongoing Medical and Mental Health Care, Sick Call Referral Form, Medical and Mental Health Practitioners Interviews.

Findings: A. The Lyle B. Medlock Residential Treatment Center policy does outline the procedure for a sexual abuse victim and or abuser being offered an evaluation who have been victimized including receiving ongoing medical and mental health care. B, D, E, F and G. The facility did not identify any youth requiring ongoing medical and mental health care as a sexual abuse victim and or abuser, but did provide written evidence stating the these services would be provided to these youth who have been adjudicated and who are assigned to their post detention facility, that these services are provided free of charge to the youth as well as other treatment i.e. STI's as deemed appropriate by the medical and mental health practitioner will be offered. This is an all male facility whereas pregnancy test would not be required. C. The Medical and Mental Health staff stated during their interviews that their mental health and medical services are consistent with the community level of care and at no cost to the victim whether they name the abuser or cooperates with the investigation. H. The facility's policy states that they will attempt to conduct an evaluation on the committed youth abuser within 60 days of learning of the abuse history and offer treatment when deemed appropriate by the mental health practitioner. The facility reported that there were zero youth identified as a sexual abuse victim and or abuser who required ongoing medical and mental health services during the last 12 months thus demonstrating compliance with this standard.

Corrective Action Findings: None.

Standard 115.386 Sexual abuse incident reviews

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy and Evidence reviewed: Zero Tolerance Policy, Sexual Abuse Review Team Initial and Ongoing Meeting Minutes, Monthly Meeting Notification (if applicable), Administrative Investigative Case, Interviews with a Sexual Abuse Review Team member and the PREA Coordinator.

Findings: A. The Lyle B. Medlock Residential Treatment Center policy does outline the process for conducting sexual abuse reviews for substantiated and unsubstantiated cases of sexual abuse with the understanding that a review would not be held for Unfounded cases. B and C. The facility's sexual abuse team is represented by the Facility Superintendent, the PREA Compliance Manager, a Shift Supervisor, a designated Investigator, a Mental health practitioner (psyvchologist), which is convened within 30 days of the conclusion of an administrative and or criminal investigation for sexual abuse. D and E. The Team considers the six (6) elements pertaining to the review of the allegation and then submits its findings to the Facility Superintendent The meeting is facilitated by the Facility Superintendent and the PREA Compliance Manager as Co-Chair, who prepares the minutes and report recommendations for improvement as applicable. The facility needed not to provide written evidence to indicate that there were sexual abuse allegations to review in last 12 months because there were none. The facility did provide written evidence that an initial meeting occurred in August of 2015 which established this team and that a memorandum will be generated monthly to demonstrate that the sexual abuse review team remains active. They did provide a memorandum for the month September of 2015 indicating that there were no sexual abuse allegations that were substantiated or unsubstantiated which would require the SART Team to convene. The facility did provide a copy of the SART meeting convened for October 2015 for the Substantiated finding of the youth on youth sexual harassment. Although the standards require that a review occur for sexual abuse, since the incident was reported and administratively investigated with a finding of Substantiated, this facility demonstrated that their SART was operationalized and active. A recommended "best practice" by the auditor to the PREA Coordinator was that the PREA Compliance Manager generate an email monthly to all the Sexual Abuse Review Team members to keep them apprised if there are any sexual abuse substantiated or unsubstantiated findings that need reviewing for that month. The facility has reported zero allegations of sexual abuse during the last 12 months and that zero reviews were conducted thus demonstrating compliance with this standard.

Corrective Action Findings: None

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 and Evidence reviewed: Zero Tolerance Policy, DOJ Survey for Sexual Victimization for 2014, Administrative and Criminal Investigative Cases, Sexual Abuse and Sexual Harassment Allegations for 2014, Trends, Implemented Recommendations and the PREA Coordinator's Interview.

Findings: A. The Lyle B. Medlock Residential Treatment Center and the Dallas County Juvenile Department's policies does outline the procedure for collecting uniform data on all allegations of sexual abuse and sexual harassment at all their facilities including private contractors as applicable including using a standardized instrument to demonstrate compliance with this standard. B and C. The facility provided written evidence of their annual DOJ Survey of Sexual Victimization, the last one being for 2014, as the standardized instrument utilized for capturing this aggregate data annually, which was corroborated through the interview with the agency's PREA Coordinator and viewed on the agency's website. D and E. The facility's PREA Coordinator indicated during her interview that she reviews, collects all the data including investigative reports and files, including those from private facilities in which they contract for the confinement of its youth, identifies trends, implements recommendations and documents the reason for not doing so locally. The PREA Coordinator also stated that upon request, this information has been provided to DOJ no later than June 30th of each year or as otherwise directed by BJA thus demonstrating compliance with this standard.

Corrective Action Findings: None.

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 and Evidence reviewed: Zero Tolerance Policy, DOJ Survey for Sexual Victimization for 2014, Facility's Aggregated Sexual Abuse and Sexual Harassment Data, Data Collection Memorandum and Instrument, Agency's Website and PREA Compliance Manager and PREA Coordinator Interviews.

Findings: A and B. The Lyle B. Medlock Residential Treatment Center policy does outline the review of aggregate sexual abuse and sexual harassment data, including that of their private contractors, how they will assess it to improve the effectiveness of the agency's policies, practices and training, to identified problems and to provide directions for taking corrective action. The facility did provide written evidence that demonstrated a review of the data collected, identification of trends, problem areas, and subsequent corrective action to be taken in accordance with this standards does occur. C and D. The agency's PREA Coordinator indicated during her interview that she prepares a report from these findings, comparing the current year's data with the prior year data, redacting any information that may present a clear and

specific threat to the safety and security of the facilities, obtains approval from the agency's head, makes this report available on the agency's website or other means and provides a copy to the Department of Justice upon their request thus demonstrating compliance with this standard.

Corrective Action Findings: None

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.

Policy and Evidence reviewed: Zero Tolerance Policy, Agency's Website, DOJ Survey for Sexual Victimization for 2014, Data Collection Memorandum and Instrument, Data Storage and Publication Policy, and the interview with the PREA Coordinator.

Findings: The Lyle B. Medlock Residential Treatment Center policy does outline that all sexual abuse data is under their control, that all personal identifiers are redacted and that this information collected is retained securely. A review of this Zero Tolerance policy, the interview with the PREA Coordinator, a review of the agency's website and a review of the referenced documents corroborated this practice. Furthermore, the facility's policy states that all sexual abuse data is retained securely and will be maintained for at least 10 years after the date of the initial collection.

Corrective Action Findings: None.

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.

Jerome K. Williams November 3rd, 2015

Auditor Signature Date