

Prison Rape Elimination Act (PREA) Audit Report Juvenile Facilities

☐ Interim ☒ Final

Date of Interim Audit Report: February 8, 2021 ☐ N/A

If no Interim Audit Report, select N/A

Date of Final Audit Report: April 27, 2021

Auditor Information

Name: Robert Burns Latham	Email: RobertBLatham@icloud.com
Company Name: Latham Corrections Consulting LLC	
Mailing Address: 677 Idlewild Circle	City, State, Zip: Birmingham, Alabama 35205
Telephone: 205-746-1905	Date of Facility Visit: December 7-8, 2020

Agency Information

Name of Agency: Memphis Recovery Centers			
Governing Authority or Parent Agency (If Applicable): Memphis Recovery Centers Board of Directors			
Address: 1234 Poplar Avenue		City, State, Zip: Memphis, Tennessee 38104	
Mailing Address: 219 North Montgomery Street		City, State, Zip: Memphis, Tennessee 38104	
The Agency Is:	<input type="checkbox"/> Military	<input type="checkbox"/> Private for Profit	<input checked="" type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input type="checkbox"/> State	<input type="checkbox"/> Federal
Agency Website with PREA Information: www.memphisrecovery.com			

Agency Chief Executive Officer

Name: Michael McLoughlin	
Email: mikem@memphisrecovery.com	Telephone: 901-272-7751

Agency-Wide PREA Coordinator

Name: Detra D. Hopkins	
Email: dhopkins@memphisrecovery.com	Telephone: 901-272-7751
PREA Coordinator Reports to: Sherry Butler	Number of Compliance Managers who report to the PREA Coordinator: 2

Facility Information

Name of Facility: Youth Development

Physical Address: 1234 Poplar Avenue

City, State, Zip: Memphis, Tennessee 38104

Mailing Address: 219 North Montgomery Street

City, State, Zip: Memphis, Tennessee 38104

The Facility Is:

☐ Military

☐ Private for Profit

☒ Private not for Profit

☐ Municipal

☐ County

☐ State

☐ Federal

Facility Website with PREA Information: www.memphisrecovery.com

Has the facility been accredited within the past 3 years? ☒ Yes ☐ No

If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years):

☐ ACA

☐ NCCHC

☐ CALEA

☒ Other (please name or describe: Council on Accreditation (COA))

☐ N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:
none

Facility Administrator/Superintendent/Director

Name: Donna Armstrong

Email: darmstrong@memphisrecovery.com

Telephone: 901-272-7751

Facility PREA Compliance Manager

Name: Tesa Terry

Email: tterry@memphisrecovery.com

Telephone: 901-272-7751

Facility Health Service Administrator ☒ N/A

Name: Click or tap here to enter text.

Email: Click or tap here to enter text.

Telephone: Click or tap here to enter text.

Facility Characteristics

Designated Facility Capacity:

20

Current Population of Facility:	15	
Average daily population for the past 12 months:	14	
Has the facility been over capacity at any point in the past 12 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Which population(s) does the facility hold?	<input type="checkbox"/> Females <input type="checkbox"/> Males <input checked="" type="checkbox"/> Both Females and Males	
Age range of population:	13-17	
Average length of stay or time under supervision	three to six months	
Facility security levels/resident custody levels	Level III	
Number of residents admitted to facility during the past 12 months	43	
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:	42	
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:	42	
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	<input type="checkbox"/> Federal Bureau of Prisons <input type="checkbox"/> U.S. Marshals Service <input type="checkbox"/> U.S. Immigration and Customs Enforcement <input type="checkbox"/> Bureau of Indian Affairs <input type="checkbox"/> U.S. Military branch <input type="checkbox"/> State or Territorial correctional agency <input type="checkbox"/> County correctional or detention agency <input type="checkbox"/> Judicial district correctional or detention facility <input type="checkbox"/> City or municipal correctional or detention facility (e.g. police lockup or city jail) <input type="checkbox"/> Private corrections or detention provider <input type="checkbox"/> Other - please name or describe: Click or tap here to enter text. <input checked="" type="checkbox"/> N/A	
Number of staff currently employed by the facility who may have contact with residents:	15	
Number of staff hired by the facility during the past 12 months who may have contact with residents:	12	
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	0	
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0	
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0	

Physical Plant

Number of buildings: Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.	2
Number of resident housing units: Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.	2
Number of single resident cells, rooms, or other enclosures:	0
Number of multiple occupancy cells, rooms, or other enclosures:	4
Number of open bay/dorm housing units:	0
Number of segregation or isolation cells or rooms (for example, administrative, disciplinary, protective custody, etc.):	0
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Medical and Mental Health Services and Forensic Medical Exams

Are medical services provided on-site?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Are mental health services provided on-site?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

<p>Where are sexual assault forensic medical exams provided? Select all that apply.</p>	<p><input type="checkbox"/> On-site</p> <p><input checked="" type="checkbox"/> Local hospital/clinic</p> <p><input checked="" type="checkbox"/> Rape Crisis Center</p> <p><input type="checkbox"/> Other (please name or describe: (Shelby Rape Crisis Center)</p>	
<p align="center">Investigations</p>		
<p align="center">Criminal Investigations</p>		
<p>Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:</p>	<p align="center">0</p>	
<p>When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.</p>	<p><input type="checkbox"/> Facility investigators</p> <p><input type="checkbox"/> Agency investigators</p> <p><input checked="" type="checkbox"/> An external investigative entity</p>	
<p>Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)</p>	<p><input checked="" type="checkbox"/> Local police department</p> <p><input type="checkbox"/> Local sheriff's department</p> <p><input type="checkbox"/> State police</p> <p><input type="checkbox"/> A U.S. Department of Justice component</p> <p><input type="checkbox"/> Other (please name or describe: Click or tap here to enter text.)</p> <p><input type="checkbox"/> N/A</p>	
<p align="center">Administrative Investigations</p>		
<p>Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?</p>	<p align="center">0</p>	
<p>When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply</p>	<p><input type="checkbox"/> Facility investigators</p> <p><input type="checkbox"/> Agency investigators</p> <p><input checked="" type="checkbox"/> An external investigative entity</p>	
<p>Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)</p>	<p><input type="checkbox"/> Local police department</p> <p><input type="checkbox"/> Local sheriff's department</p> <p><input type="checkbox"/> State police</p> <p><input type="checkbox"/> A U.S. Department of Justice component</p> <p><input checked="" type="checkbox"/> Other (please name or describe: (Tennessee Department of Children's Services (DCS)</p> <p><input type="checkbox"/> N/A</p>	

Audit Findings

Audit Narrative (including Audit Methodology)

The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-onsite audit, onsite audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.

Introduction

The Prison Rape Elimination Act (PREA) onsite audit of Youth Development (YD), located at 1234 Poplar Avenue, Memphis Tennessee 38104, was conducted December 7-8, 2020. The parent agency for Youth Development is Memphis Recovery Centers. and is also located at 1234 Poplar Avenue, Memphis Tennessee 38104. The audit was conducted by Robert B. Latham from Birmingham, Alabama, who is a U.S. Department of Justice Certified PREA auditor for juvenile facilities. The auditor conducted the audit as a single auditor with no additional support staff. The facility contacted the auditor regarding the audit and a contract was agreed upon and signed September 12, 2019. There are no known existing conflicts of interest or barriers to completing the audit. The facility was last audited August 5, 2017, with 100% compliance with the PREA Juvenile Standards.

Mission Statement

Memphis Recovery centers provides compassionate treatment service for youth and adults from suffering substance addiction, and cooccurring disorders using professional methods to improve spiritual, physical, emotional, social and occupational well-being.

Value Statement

The dignity of the Memphis Recovery Centers' (MRC) patients and staff is protected and held in high regard by the MRC management team and Board of Directors. MRC does not recruit staff or admit patients with regard to culture, race, ethnic or national origin, religion or gender. MRC recruits personnel based on credentials and "content of character". MRC admits patients based on need and availability. Further, MRC does not purchase goods or services with regard to culture, race, ethnic or national origin, religion or gender. It is with this disposition that MRC seeks to better the community, contribute to the nation one person, one family at a time. Toward that end MRC serves all under its authority with genuine concern and quality of life.

Audit Methodology Pre-Onsite Audit Phase

Prior to being onsite, the PREA Coordinator and the auditor had discussions concerning access to the facility and staff, the audit process, logistics for the onsite phase of the audit, and goals and expectations. The PREA Coordinator was very receptive to the audit process and was well informed of the role of the auditor and the expectations during each stage of the PREA audit.

Notice of Audit Posting and Timeline

The audit notice was posted October 26, 2020. The notices were in English and Spanish. The audit notice was posted in color using a large font and easy-to-read. The audit notices were placed throughout the facility, in places visible to all residents and staff. Pictures of the posted audit notices were emailed to the auditor on October 20, 2020 for verification. Further verification of their placement

was made through observations during the onsite review. The audit notices included a statement regarding confidentiality of resident and staff correspondence with the auditor. No correspondence was received during any phase of the audit.

Pre-Audit Questionnaire (PAQ) and Supporting Documentation

The PAQ and supporting documentation was received November 16, 2020. The PAQ was completed on November 13, 2019. The PAQ was revised April 19, 2021 to include omitted information. The documentation was received on a flash drive. The documentation was well organized by standard. The auditor reviewed the PAQ, policy, procedures, and some supporting documentation. Using the Auditor Compliance Tool and Checklist of Documentation, the auditor's initial analysis and review of the information determined it to be well organized.

Requests of Facility Lists

Youth Development provided the following information for interview selections and document sampling:

Complete Resident Roster	An up-to-date roster was provided upon arrival to the facility.
Youthful inmates/detainees	N/A (Memphis Recovery Centers does not accept youthful inmates/detainees.)
Residents with physical disabilities	None were identified.
Residents with cognitive disabilities	None were identified.
Residents who are Limited English Proficient	None were identified.
Lesbian, Gay, and Bisexual Residents	3
Transgender or Intersex Residents	None were identified.
Residents in segregated housing	N/A (Memphis Recovery Centers does not have segregated housing.)
Residents in isolation	None were identified or observed.
Residents who reported sexual abuse	None were identified.
Residents who reported sexual victimization during risk screening	3
Complete Staff Roster	The staff roster and schedule were provided upon arrival to the facility.
Specialized Staff	Specialized staff were identified on the roster.
All contractors who have contact with the residents	0
All volunteers who have contact with the residents	0
All grievances/allegations made in the 12 months preceding the audit	Zero (0) grievances concerning allegations of sexual abuse and sexual harassment
All allegations of sexual abuse and sexual harassment reported for investigation in the 12 months preceding the audit	0
Detailed list of number of sexual abuse and sexual harassment allegations in the 12 months preceding the audit	0
All hotline calls made in the 12 months preceding the audit	Zero (0); All allegations of sexual abuse or sexual harassment are reported through the DCS hotline.

External Contacts

The following external contacts were made:

Just Detention International	Just Detention International reviewed their database for records and information and reported no information for the preceding 12 months.
Community Based Organizations (CBOs)	Shelby Rape Crisis Center
The Tennessee Department of Children Services Hotline	The auditor contacted the Tennessee Department of Children Services Hotline at 877-237-0004.
SAFE/SANE Programs	SANEs are available through Shelby Rape Crisis Center and through Le Bonheur Children's Hospital.

Research

Tennessee Mandated Reporter Law - Statutory citation(s): T.C.A. §§ 37-1-401, 37-1-403, 37-1-410, 37-1-412, 37-1-413, 37-1-602, 37-1-605, 40-35-111.

- Who is required to report sexual abuse?
Any person, including, but not limited to, any: Physician, osteopathic physician, medical examiner, chiropractor, nurse or hospital personnel engaged in the admission, examination, care or treatment of persons; Any other health or mental health professional; Practitioner who relies solely on spiritual means for healing; School teacher or other school official or personnel; Judge of any court of the state; Social worker, day care center worker, or other professional child care, foster care, residential or institutional worker; Law enforcement officer; Authority figure at a community facility, including any facility used for recreation or social assemblies for educational, religious, social, health or welfare purposes, including, but not limited to, facilities operated at schools, the boy or girl scouts, the YMCA or YWCA, the boys and girls club or church or religious organizations; or
- When is a report required?
Knowledge or reasonable cause to suspect that a child has been sexually abused, regardless of whether such person knows or believes that the child has sustained any apparent injury as a result of such abuse.
- Where does it go? The local office of the Department of Children's Services (DCS) or to the judge having juvenile jurisdiction or to the office of the sheriff or the chief law enforcement official of the municipality where the child resides. Each report of known or suspected child sexual abuse occurring in a facility licensed by the department of mental health and substance abuse services, or any hospital, shall also be made to the local law enforcement agency in the jurisdiction where such offense occurred.
- What timing and procedural requirements apply to reports?

Reports must be made immediately. Reports may be made via telephone or otherwise, on the Department of Children's Services Central Intake Division hotline at 1-877-237-0004 (1-877-54ABUSE) or online (at: <https://apps.tn.gov/carat/referral/emergency.html>).

Onsite Audit Phase

Entrance briefing

An entrance briefing was held with the PREA Coordinator, and Facility Director. Introductions were made and an in-depth discussion of the standards, policy, and documentation was held. The agenda

for the two days was discussed, and the auditor began the audit by interviewing staff and residents. The site review was conducted in the morning of the second day of the audit.

Site review

The auditor had access to, and observed, all areas of the facility. The auditor was provided a diagram of the physical plant during the pre-onsite phase of the audit and was thus familiar with the layout of the facility. In addition to the bedrooms and bathrooms, the auditor reviewed intake, outside recreation, two classrooms, the kitchen, two multi-purpose rooms, and staff offices. On the first day of the onsite audit the population of the facility was 13 juveniles: ten (10) female and two (2) male.

Processes and areas observed

The auditor observed the intake and risk screening to better understand the process. A grievance box and grievance forms were easily accessible to the residents. Residents are able to keep pencils. The grievance box is checked daily.

Phones for reporting sexual abuse, sexual harassment or for contacting external crisis intervention services are available upon request. The staff conducting the site review described the showering process, reiterated there were no cameras, pointed out the PREA posters with telephone numbers for reporting sexual abuse and sexual harassment. The PREA posters are prominently placed in areas of the facility frequented by the residents. The auditor informally asked residents about reporting and basic information about sexual safety at the facility. The auditor observed on both days of the audit that ratios exceeded 1:5.

Specific area observations

There are no cameras in the facility. Wherever residents were present, the auditor observed staff actively supervising the residents. Classrooms were observed to be compliant with the 1:5 ratio requirements. Staff supervision mitigates blind spots.

Exit briefing

An exit briefing was held with the PREA Coordinator. The auditor discussed the onsite audit. The auditor did have areas of concern. Some additional documentation for residents interviewed was requested and provided. The documentation provided by the facility, prior to the onsite phase of the audit, mostly covered policy and not much additional supporting documentation. Interviews with the staff and residents demonstrated training and education were effective.

Post-Onsite Audit Phase

The interim report was submitted February 9, 2021. The auditor provided an issues log detailing corrective actions. The PREA Coordinator and auditor communicated frequently, and all corrective actions were completed as of April 27, 2021. The final report was submitted April 27, 2021.

Discussion of Corrective Actions

115.311

Updated organizational chart showing positions of PREA Coordinator and PREA Compliance Manager was needed. Corrective action is complete as of March 9, 2021. Organizational chart was provided to the auditor for verification.

115.313

- A PREA compliant staffing plan was developed. The auditor reviewed the staffing plan for verification. Corrective action is complete as of January 21, 2021.

- Additional unannounced rounds for three months were provided. The auditor reviewed the additional unannounced rounds for verification. Corrective action is complete as of March 11, 2021.

115.315

Cross-Gender and Transgender Pat Searches training was completed. The auditor reviewed training logs for verification. Corrective action is complete as of March 10, 2021.

115.317

Employee questionnaire (hire, evaluations, and promotions). The three questions were added for new hires and promotions and the three questions are asked annually. Documentation was provided to the auditor for verification. Corrective action is complete as of April 27, 2021.

115.322

"The agency shall have in place a policy to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations unless the allegation does not involve potentially criminal behavior. The agency shall publish such policy on its website or, if it does not have one, make the policy available through other means. The agency shall document all such referrals."

The agency added a link to DCS Policy 18.8 on the website. The auditor reviewed the website for verification. Corrective action is complete.

115.335

Specialized training for medical and mental health staff was needed. Corrective action is complete as of March 1, 2021. The auditor reviewed training records for verification.

115.341

DCS form CS-1237, Safe Housing Re-Assessment, was completed for all residents who have been at MRC for three months. Reassessments were also required for an additional three months to show the standard provision is fully in practice. The auditor reviewed Safe Housing Re-Assessments for verification. Corrective action is complete as of March 11, 2021.

115.354

Third party reporting - "The agency shall establish a method to receive third-party reports of sexual abuse and sexual harassment and shall distribute publicly information (website) on how to report sexual abuse and sexual harassment on behalf of a resident."

The agency added the PREA Coordinator's name, email address/link, and telephone number to the website under the heading: third-party reporting. The auditor reviewed the website for verification. Corrective action is complete.

115.388

PREA compliant Annual Reports were required. The agency added sexual abuse and sexual allegations data for 2014-2020 on the website. The auditor reviewed the website for verification. Corrective action is complete.

115.403 All previous audit reports were published on the MRC website. The auditor reviewed the website for verification. Corrective action is complete.

Interviews Logistics

Location and Privacy

Interviews were held in a classroom that provided privacy and was centrally located to minimize disruption of daily activities and programming. The classroom was large and allowed for proper ventilation and socially distanced interviews.

Selection Process

Specialized staff were selected based on their respective duties in the facility. Eleven (11) direct care staff, randomly selected from every shift, were interviewed using the random staff interview protocol. This represents the total number of staff on duty during the two days of the audit. The resident population was thirteen (13) on the first day of the audit. Six (6) residents, randomly selected from each housing unit, were interviewed using the random resident interview questionnaire. Target interviews were selected by information provided by the facility and resident interviews. Three (3) residents who reported sexual victimization during risk screening were identified. Three (3) resident identified as bisexual.

Interview Protocols	Number of Interviews
Administration and Agency Leadership	
Agency Head Designee (COO)	1
Facility Director	1
PREA Coordinator	1
PREA Compliance Manager	1
Medical Staff	N/A
Mental Health Staff	1
Non-Medical Staff Involved in Cross-Gender Strip Searches or Visual Body Cavity Searches	N/A
Administrative (Human Resources) Staff	1
Agency Contract Administrator	N/A
Intermediate or Higher-level Facility Staff (unannounced rounds)	1
SAFE and SANE	1
Investigative Staff	1 (DCS Investigator)
Staff who Perform Screening for Risk of Victimization and Abusiveness	1
Staff who Supervise Residents in Isolation (no isolation)	N/A
Staff on the Incident Review Team	1
Designated Staff Member Charged with Monitoring Retaliation	1
Security First Responders	1
Non-Security Staff First Responders	N/A
Intake Staff	1
Random Sample of Staff	
First Shift	6
Second Shift	3
Second Shift	3
Total Random Sample of Staff	11 (all available)
Volunteers Contractors who have Contact with Residents	
Volunteers	0
Contractors	0
Residents	

Random Sample of Residents from all Housing Units	6
Targeted Residents	
Residents who Reported a Sexual Abuse	None identified
Residents with Cognitive Disabilities	None identified
Residents with Physical Disabilities	None identified
Limited English Proficient Residents	None identified
Gay, Lesbian, and Bisexual Residents	3
Transgendered and Intersex Residents	None identified
Residents in Isolation	None identified
Residents who Disclosed Prior Sexual Victimization During Risk Screening	3
Interview Totals	
Total Number of Staff Interviews	25
Total Number of Resident Interviews	10
Total Number of Interviews	35

Interviewed Residents Length of Time at Facility

Days or Months	Number of Residents
1 Day to 31 Days	1
32 Days to 6 Months	9
7 Months to 12 Months	0
13 Months Plus	0
Total	10

Records Review

Name of Record	Total Records Reviewed
Personnel Records/Documentation	23
Volunteers and Contractors Files/Documentation	2
Training Files/Documentation/Records	27
Resident Records	16
Medical/Mental Health Records and Documentation for Victims	0
Grievance Forms (Sexual Abuse and Sexual Harassment)	0
All Incident Reports (Sexual Abuse and Sexual Harassment)	0
Investigation Records (Sexual Abuse and Sexual Harassment)	0

Investigative Files

Youth-on-Youth Sexual Victimization	Substantiated	Unsubstantiated	Unfounded
Nonconsensual Sexual Acts	0	0	0
Abusive Sexual Contact	0	0	0
Sexual Harassment	0	0	0
Staff-on-Youth Sexual Abuse			
Staff Sexual Misconduct	0	0	0
Staff Sexual Harassment	0	0	0

Reporting Method	Sexual Abuse		Sexual Harassment	
	Youth-on-Youth	Staff-on-Youth	Youth-on-Youth	Staff-on-Youth
Hotline	0	0	0	0

Grievance	0	0	0	0
Verbal Report	0	0	0	0
Anonymous	0	0	0	0
Third Party	0	0	0	0
Reports by Staff	0	0	0	0

Facility Characteristics

The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate, resident or detainee population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

Characteristics Related to PREA and Sexual Safety

Introduction	
Parent Agency	Memphis Recovery Centers
Other Significant Relationship Information	Contracts with the Tennessee Department of Children's Services
Facility Name	Youth Development
Facility Address	1234 Poplar Avenue, Memphis, Tennessee 38104
Age of Facility	41 years
Total Facility Rated Capacity	20
Resident Population Size and Makeup	
Average daily population in the last 12 months	14
Actual population on day 1 of the onsite portion of the audit	13
Population Gender	Female and Male
Population Ethnicity	Multiethnic
Average Length of Stay	three to six months
Staff Size and Makeup	
Total Staff Size	15
Number of Security Staff	N/A
Types of Supervision Practiced:	Direct Supervision
Number of Volunteers who may have contact with residents	0
Number of Contractors who may have contact with residents	0
Number of Interns who may have contact with residents	0
Number and Type of Housing Units	
Number of single-occupancy cells	0
Number of multiple-occupancy cells	4
Number of open-bay dorms	0
Number of segregation/isolation units	0
Number of medical units	0
Number of closed units	0
Type of Supervision (direct or indirect)	Direct

Video Monitoring	no
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Facility Operations

Physical Plant Description

Memphis Recovery Centers is located at 1234 Poplar Avenue, Memphis, Tennessee 38104. Youth Development is a twenty (20) bed male/female facility. The population was thirteen (13) on the first day of the on-site audit. The house has two multi-purpose rooms, a laundry room and a kitchen. The youth do their own laundry according to a schedule and assist with heating and serving the meals. The boys reside on the third floor. There are two rooms with four beds each and a bathroom with a shower. The girls reside on the second floor. There are three rooms with four beds each and a bathroom with two toilets and two showers with shower curtains. Across the courtyard there is a second building with two classrooms and staff offices.

Services Available

Memphis Recovery Centers provides youth-focused addiction treatment approaches, which include:

- Individual counseling
- Group and family therapy
- Life skills training
- Anger management classes
- Drug and alcohol education classes for patients and family
- Music and art therapy
- A broad spectrum of assessments and information for parents and involved family

Transitions Learning Center

Memphis Recovery Centers operates an in-house school for youth in treatment. The school, known as Transitions Learning Center (TLC), provides a traditional classroom setting with a low patient-staff ratio that enables youth to excel in an academic environment. MRC communicates directly with the outside public and private schools and other primary treatment providers to offer an added resource for balancing treatment planning and academics.

Summary of Audit Findings

The summary should include the number and list of standards exceeded, number of standards met, and number and list of standards not met.

Auditor Note: No standard should be found to be “Not Applicable” or “NA”. A compliance determination must be made for each standard.

Standards Exceeded

Number of Standards Exceeded: 2

List of Standards Exceeded: 115.317, 115.331

Standards Met

Number of Standards Met: 41

Standards Not Met

Number of Standards Not Met: 0

List of Standards Not Met: [Click or tap here to enter text.](#)

PREVENTION PLANNING

Standard 115.311: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

All Yes/No Questions Must Be Answered by The Auditor to Complete the Report

115.311 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes ☐ No

115.311 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities? ☒ Yes ☐ No

115.311 (c)

- If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA
- Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. MRC YD Pre-Audit Questionnaire

Documents (Corrective Action):

1. MRC/YD Organizational Chart

Interviews:

1. PREA Coordinator
2. PREA Compliance Manager

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.311 (a)

PAQ: The agency has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract. The facility has a policy outlining how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment. The policy includes sanctions for those found to have participated in prohibited behaviors. The policy includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents.

MRC policy states MRC holds a zero tolerance for all forms of sexual abuse and sexual harassment.

DCS policy states The Department of Children's Services (DCS) shall be committed to a zero-tolerance standard for all forms of sexual abuse/assault/misconduct/harassment or rape within its Youth Development Center facilities and Contract Agencies that provide congregate care for children/youth and shall be committed to reducing the risk of sexual abuse, sexual harassment, assault, misconduct and rape through implementation of the Prison Rape Elimination Act (PREA) as outlined in Public Law 108-79, Section 3.

The purpose of this policy is to provide guidelines for DCS's zero-tolerance for all forms of sexual abuse and sexual harassment, and the implementation of the Prison Rape Elimination Act (PREA) to provide a safe, humane, and appropriately secure environment free from threat of sexual abuse/assault/misconduct/harassment or rape is provided for all children/youth that live in congregate care settings.

The procedures outline how Memphis Recovery Centers will implement this zero-tolerance approach to preventing, detecting, and responding to sexual abuse, assault, misconduct, harassment, or rape,

including all sections of the procedures and any revisions thereof. Definitions of prohibited behaviors are found in a glossary at the end of the policy.

115.311 (b)

PAQ: The agency employs or designates an upper-level, agency-wide PREA Coordinator. The PREA Coordinator has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards at the facility. The position of the PREA Coordinator is not in the agency's organizational structure.

The Memphis Recovery Centers YP Program Director serves as the PREA Coordinator. The PREA Coordinator is not identified on the agency's organizational chart. The PREA Coordinator confirmed she has sufficient time and authority to develop, implement and oversee agency efforts to comply with the PREA standards.

115.311 (c)

PAQ: The facility has designated a PREA Compliance Manager. The PREA Compliance Manager has sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards. The position of the PREA Compliance Manager is not in the agency's organizational structure.

The YD Program Manager serves as the PREA Compliance Manager. The PREA Compliance Manager is not identified on the facility's organizational chart. The PREA Compliance Manager confirmed she has sufficient time and authority to develop, implement and oversee facility efforts to comply with the PREA standards.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor confirmed the agency and facility is fully compliant with this standard regarding zero tolerance of sexual abuse and sexual harassment and designation of an agency wide PREA Coordinator. Corrective action was required.

113.311 (b) and (c)

Updated organizational chart showing position of PREA Coordinator and PREA Compliance Manager was needed. Organizational chart was provided to the auditor for verification. Corrective action is complete as of March 9, 2021.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.312 (a)

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to adopt and comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☐ Yes ☐ No ☒ NA

115.312 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. MRC YD Pre-Audit Questionnaire

Findings (By Provision):

115.312 (a)

Memphis Recovery Centers is not a public agency that contracts for the confinement of its residents. The Tennessee Department of Children's Services (DCS) contracts for the confinement of its residents with Memphis Recovery Centers.

115.312 (b)

Memphis Recovery Centers is not a public agency that contracts for the confinement of its residents.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor confirmed the agency and facility is fully compliant with this standard regarding contracting with other entities for the confinement of residents. No corrective action is required.

Standard 115.313: Supervision and monitoring

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.313 (a)

- Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?
☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Generally accepted juvenile detention and correctional/secure residential practices? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any judicial findings of inadequacy? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from Federal investigative agencies? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from internal or external oversight bodies? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The number and placement of supervisory staff? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Institution programs occurring on a particular shift? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any applicable State or local laws, regulations, or standards? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors? ☒ Yes ☐ No

115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? ☒ Yes ☐ No
- In circumstances where the staffing plan is not complied with, does the facility document all deviations from the plan? (N/A if no deviations from staffing plan.) ☐ Yes ☐ No ☒ NA

115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) ☒ Yes ☐ No ☐ NA
- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) ☒ Yes ☐ No ☐ NA
- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) ☒ Yes ☐ No ☐ NA
- Does the facility ensure only security staff are included when calculating these ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) ☒ Yes ☐ No ☐ NA
- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? ☒ Yes ☐ No

115.313 (d)

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section? ☒ Yes ☐ No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns? ☒ Yes ☐ No
- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility’s deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan? ☒ Yes ☐ No

115.313 (e)

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA
- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA
- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. 2020 Staffing Plan Assessment
4. Unannounced Rounds
5. MRC YD Pre-Audit Questionnaire

Documents (Corrective Action):

1. Staffing Plan

Interviews:

1. Facility Director
2. PREA Coordinator
3. Interview with the PREA Compliance Manager
4. Intermediate or Higher-Level Facility Staff

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):**115.313 (a)**

PAQ: Since the 2017 PREA audit:

1. The average daily number of residents: 15
2. The average daily number of residents on which the staffing plan was predicated: 15

Policy states The Agency develops, implements, and documents a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect children/youth against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, Agency takes into consideration:

1. Generally accepted juvenile detention and correctional/secure residential practices;
2. Any judicial finding of inadequacies;
3. Any findings of inadequacy from federal investigative agencies;
4. Any finding of inadequacy from internal or external oversight bodies;
5. All components of the facilities physical plant (including “blind spots” or areas where staff or children/youth may be isolated);
6. The composition of the children/youth population;
7. The number and placement of supervisory staff;
8. Institution programs occurring on a particular shift;
9. Any applicable State or local laws, regulations, or standards;
10. The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and
11. Any other relevant factors.

The Program Director and PREA Compliance Manager confirmed MRC had not developed a staffing plan that, maintains adequate staffing levels to protect residents against sexual abuse, considers video monitoring as part of the plan, and documents the plan. When assessing staffing levels and the need for video monitoring, the staffing plan considers: generally accepted juvenile detention and correctional/secure residential practices; any judicial findings of inadequacy; any findings of inadequacy from Federal investigative agencies; any findings of inadequacy from internal or external oversight bodies; all components of the facility’s physical plant (including “blind spots” or areas where staff or residents may be isolated); the composition of the resident population; the number and placement of supervisory staff; institution programs occurring on a particular shift; any applicable State or local laws, regulations, or standards; the prevalence of substantiated and unsubstantiated incidents of sexual abuse; and any other relevant factors. The Program Director stated she checks for compliance with the staffing plan through reviewing scheduling. This was addressed through corrective action.

115.313 (b)

PAQ: Each time the staffing plan is not complied with, the facility documents and justifies all deviations from the staffing plan. Policy states MRC and its employees shall comply with the following staffing plan except during limited and discrete exigent circumstances and shall fully document any deviations from this plan during such circumstances.

Policy states the Agency complies with the staffing plan except during limited and discrete exigent circumstances, and fully documents deviations from the plan during such circumstances.

The Program Director confirmed there have been no circumstances in which the facility has been unable to meet the requirements of the staffing plan. The facility would document all instances of non-compliance with the staffing plan and include an explanation for non-compliance.

115.313 (c)

PAQ:

1. The facility is obligated by law, regulation, or judicial consent decree to maintain staffing ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours.
2. The facility does not maintain staff ratios of a minimum of 1:8 during resident waking hours.
3. The facility maintains staff ratios of a minimum of 1:16 during resident sleeping hours.

In the past 12 months:

1. The facility has not deviated from the staffing ratios of 1:8 security staff during resident waking hours more than what would be considered more than limited and discrete exigent circumstances.
2. The number of times the facility deviated from the staffing ratios of 1:16 security staff during resident sleeping hours: Zero (0)

MRC maintains a minimum ratio of 1:5 staff per residents during awake hours and 1:8 during sleeping hours.

The Program Director confirmed MRC is obligated by DCS to maintain ratios of staff-to-youth ratios of 1:5 staff per residents during awake hours and 1:8 during sleeping hours. She ensures the facility maintains appropriate staffing ratios through scheduling and checking in with the facility. The auditor observed the staff-to-youth ratios were in compliance with the standard requirements.

PREA Site Review: During the onsite tour of the facility, the auditor observed the classrooms and living areas were compliant with the staffing ratios.

115.313 (d)

PAQ: At least once every year the agency or facility, in collaboration with the PREA Coordinator, reviews the staffing plan to see whether adjustments are needed to:

1. The staffing plan;
2. Prevailing staffing patterns;
3. The deployment of monitoring technology; or
4. The allocation of agency or facility resources to commit to the staffing plan to ensure compliance with the staffing plan.

Policy states whenever necessary, but no less frequently than once each year, for the Agency, in consultation with the PREA Coordinator, the PREA Compliance Manager assesses, determines, and documents in form CS-1045, Staffing Plan Assessment whether adjustments are needed to:

1. The staffing plan;
2. Prevailing staffing patterns;
3. The Agency's deployment or updating of video monitoring systems and other monitoring technologies the Agency considers how such technology may enhance the Agency's ability to protect children/youth from sexual abuse; and

4. The resources the Agency has available to commit to ensure adherence to the staffing plan.

The PREA Coordinator confirmed being consulted regarding any assessments of, or adjustments to, the staffing plan. She confirmed the assessment occurs annually and is documented through the Facility Annual Staffing Report. The auditor reviewed the 2020 Staffing Plan Assessment for verification.

115.313 (e)

PAQ: The facility requires that intermediate-level or higher-level staff conduct unannounced rounds to identify and deter staff sexual abuse and sexual harassment. The facility documents unannounced rounds. The unannounced rounds cover all shifts. The facility prohibits staff from alerting other staff of the conduct of such rounds.

Policy states the Agency includes in the Post Orders search procedures for intermediate-level or higher-level supervisors to conduct and document unannounced search rounds to identify and deter staff sexual abuse and sexual harassment. Post Orders must include these search procedures for both day and night shifts.

The Program Director confirmed the PAQ responses. She stated the unannounced rounds are documented on the YD Program Shift Coverage Log. She prevents staff from alerting other staff that she is conducting the unannounced rounds by not announcing they are occurring.

The facility needs to conduct additional unannounced rounds for both day and night shifts to demonstrate this provision has been fully institutionalized. This will be addressed through corrective action.

Corrective Action

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding supervision and monitoring. Corrective action was required.

115.313 (a)

A PREA compliant staffing plan was developed. The auditor reviewed the staffing plan for verification. Corrective action is complete as of January 21, 2021.

115.313 (e)

Additional unannounced rounds for three months were provided. The auditor reviewed the additional unannounced rounds for verification. Corrective action is complete as of March 11, 2021.

Standard 115.315: Limits to cross-gender viewing and searches

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.315 (a)

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?

☒ Yes ☐ No

115.315 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances? ☒ Yes ☐ No ☐ NA

115.315 (c)

- Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches? ☒ Yes ☐ No
- Does the facility document all cross-gender pat-down searches? ☒ Yes ☐ No

115.315 (d)

- Does the facility have policies that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No
- Does the facility have procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No
- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? ☒ Yes ☐ No
- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units) ☒ Yes ☐ No ☐ NA

115.315 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? ☒ Yes ☐ No
- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? ☒ Yes ☐ No

115.315 (f)

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☐ Yes ☒ No
- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☐ Yes ☒ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual
3. DCS Policy 20.20: Guidelines for Managing Children/Youth in DCS Custody Related to Sexual Orientation, Gender Identity and Expression
4. DCS Policy 27.38-DOE: Youth Supervision
5. DCS Policy 27.39-DOE: Use of Shower and Restrooms
6. DCS Policy 31.4: Search Procedures
7. Harassment, Assault or Rape Incidents and PREA
8. DCS Core Standards: Search Procedures
9. MRC YD Pre-Audit Questionnaire

Documents (Corrective Action):

1. Staff Training Records

Interviews:

1. Interview with the PREA Coordinator
2. Interviews with a Random Sample of Staff
3. Interviews with a Random Sample of Residents
4. Interviews with Transgendered and Intersex Residents – N/A

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.315 (a)

PAQ: The facility does not conduct cross-gender strip or cross-gender visual body cavity searches of residents.

In the past 12 months:

1. The number of cross-gender strip or cross-gender visual body cavity searches of residents: Zero (0)
2. The number of cross-gender strip or cross-gender visual body cavity searches of residents that did not involve exigent circumstances or were performed by non-medical staff: Zero (0)

MRC does not conduct cross-gender strip searches or cross-gender visual body cavity searches.

115.315 (b)

PAQ: The facility does not permit cross-gender pat-down searches of residents, absent exigent circumstances.

In the past 12 months:

1. The number of cross-gender pat-down searches of residents: Zero (0)
2. The number of cross-gender pat-down searches of residents that did not involve exigent circumstance(s): Zero (0)

Pat-down searches may only be performed by staff members who are of the same gender as the youth being searched.

Policy review and interviews with staff and residents confirmed cross-gender searches are restricted.

115.315 (c)

PAQ: Facility policy requires that all cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches be documented and justified.

MRC shall document in a narrative format the reasonable cause and assessed risk of harm to self or others which triggers any search. MRC does not conduct cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches.

115.315 (d)

PAQ: The facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks (this includes viewing via video camera). Policies and procedures require staff of the opposite gender to announce their presence when entering a resident housing unit or area where residents are likely to be showering, performing bodily functions, or changing clothing.

DCS policy requires the facility to implement policies and procedures that enable Residents to shower and perform bodily functions and change clothing without non-medical staff of the opposite gender viewing the breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine room/cell or bed checks.

Resident interviews confirmed staff of the opposite gender announce their presence when entering the housing units and residents are never naked in full view of staff of the opposite gender. Showers are conducted by staff of the same gender.

Staff interviews confirmed staff of the opposite gender announce their presence when entering the housing units. Staff confirmed residents are able to dress, shower, and use the toilet without being viewed by staff of the opposite gender.

PREA Site Review: Staff conducting the tour described the shower process. Staff of the same gender monitor showers while the residents shower individually behind the privacy of shower curtain and door.

115.315 (e)

PAQ: The facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. Zero (0) such searches occurred in the past 12 months.

DCS policy transgender or intersex youth will not be searched or physically examined for the sole purpose of determining genital status. If the child/youth's genital status is unknown, this information may be determined through an interview, review of medical records or as part of the child/youth's medical check-up with a medical practitioner.

Staff interviewed confirmed they are aware they are prohibited from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status.

115.315 (f)

DCS Policy states all employees responsible for conducting searches receive training on search techniques for all types of searches. Contract Agency facilities provide search training for employees during the staff training process and record documentation in the employee's personnel file.

MRC staff members had not participated in training on conducting searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs. Staff interviewed confirmed they had not received such training. This was addressed through corrective action.

Corrective Action

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding limits to cross-gender viewing and searches. Corrective action was required.

115.315 (f)

The following information was provided as a training resource:

https://www.prearesourcecenter.org/sites/default/files/content/guidance_on_cross-gender_and_transgender_pat_searches_facilitator_guide.pdf

Cross-Gender and Transgender Pat Searches training was completed. The auditor reviewed training logs for verification. Corrective action is complete as of March 10, 2021.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.316 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? ☒ Yes ☐ No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? ☒ Yes ☐ No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? ☒ Yes ☐ No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? ☒ Yes ☐ No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? ☒ Yes ☐ No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) ☒ Yes ☐ No
- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No
- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? ☒ Yes ☐ No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

115.316 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? ☒ Yes ☐ No
- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

115.316 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: Addressing Barriers to Treatment
2. MRC Policy: Deaf and Hard of Hearing Patients
3. MRC Policy: PREA
4. DCS Policy 1.1: Providing Equal Access to Programs, Services, and Activities for Individuals with Disabilities under the Americans with Disabilities Act (ADA)

5. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
6. MRC YD Pre-Audit Questionnaire responses
7. Directory of Interpreters and Translators - Compiled by the Mental Health Association of Middle Tennessee

Interviews:

1. Interview with the PREA Coordinator
2. Interview with the Agency Head Designee (COO)
3. Interviews with Residents with Disabilities and Limited English Proficient Residents - N/A
4. Interviews with a Random Sample of Staff

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):**115.316 (a)**

PAQ: The agency has established procedures to provide disabled residents equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

Policy states appropriate provisions are made as necessary for children/youth who are limited English proficient, have disabilities (including those who are deaf or hard of hearing, those who are blind or have low vision), and those with low intellectual, psychiatric, or speech disabilities.

DCS policy states reasonable accommodations for clients with disabilities may include, but are not limited to Auxiliary Aides and Services to include:

1. Provision of qualified interpreters or other effective methods to communicate with individuals with hearing impairments at meetings, home visits, etc.;
2. Provision of TTY or TDD for communication;
3. Provision of qualified readers, taped texts, or other methods of making visually-delivered material available to clients with visual impairments; or
4. Provision of other similar services and actions, as identified according to client needs (e.g., speech impairment, mobility issues).

MRC policy states in the event Memphis Recovery Centers admits or assesses a deaf or hard of hearing individual Memphis Recovery Centers shall take reasonable efforts and within the limits of its resources to provide

1. Intake screening and counseling personnel who are knowledgeable in issues affecting evaluation, psychosocial development, and impacts of deafness/hard of hearing on individuals and families;
2. A sign language interpreter for patients whose primary means of communication is through manual communication; and
3. Telecommunication device for the deaf (TDD) access or relay system for access

The COO confirmed the agency has established procedures to provide disabled residents equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. There were no residents (with disabilities or who are limited English proficient) who were identified during the onsite audit.

115.316 (b)

PAQ: The agency has established procedures to provide residents with limited English proficiency equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

Policy states appropriate provisions are made as necessary for children/youth who are limited English proficient. Individuals with limited English proficiency requesting information from our facility or applying for our services shall have access to a "Language Identification Flashcard" for the purpose of communicating what language, they speak. MRC has on site bilingual material and provides interpreters on an as needed basis.

There were no residents identified as limited English proficient during the onsite audit.

115.316 (c)

PAQ: Agency policy prohibits use of resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under § 115.364, or the investigation of the resident's allegations.

1. The agency or facility documents the limited circumstances in individual cases where resident interpreters, readers, or other types of resident assistants are used.
2. In the past 12 months, the number of instances where resident interpreters, readers, or other types of resident assistants have been used and it was not the case that an extended delay in obtaining another interpreter could compromise the resident's safety, the performance of first-response duties under § 115.364, or the investigation of the resident's allegations: Zero (0)

Policy states the Agency does not rely on child/youth interpreters except in urgent circumstances where safety may be compromised. MRC has a directory of interpreters and translators.

Staff interviewed confirmed the agency does not use resident interpreters, resident readers, or other types of resident assistants to assist disabled residents or residents with limited English proficiency when making an allegation of sexual abuse or sexual harassment. Staff did not have knowledge of resident interpreters, resident readers, or other types of resident assistants being used in relation to allegations of sexual abuse or sexual harassment. There were no residents (with disabilities or who are limited English proficient) who were identified during the onsite audit.

Corrective Action

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding residents with disabilities and residents who are limited English proficient. No corrective action is required.

Standard 115.317: Hiring and promotion decisions**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report****115.317 (a)**

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

115.317 (b)

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone who may have contact with residents? ☒ Yes ☐ No
- Does the agency consider any incidents of sexual harassment in determining whether to enlist the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.317 (c)

- Before hiring new employees, who may have contact with residents, does the agency perform a criminal background records check? ☒ Yes ☐ No
- Before hiring new employees, who may have contact with residents, does the agency consult any child abuse registry maintained by the State or locality in which the employee would work? ☒ Yes ☐ No
- Before hiring new employees who may have contact with residents, does the agency, consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? ☒ Yes ☐ No

115.317 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No
- Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.317 (e)

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees? ☒ Yes ☐ No

115.317 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? ☒ Yes ☐ No
- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? ☒ Yes ☐ No
- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? ☒ Yes ☐ No

115.317 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? ☒ Yes ☐ No

115.317 (h)

- Does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

- ☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: Credentialing and Hiring Procedures
2. MRC Policy: Employee Recruitment
3. MRC Policy: Unacceptable Activities
4. MRC Policy: Disciplinary Actions
5. MRC Policy: Employment Termination
6. MRC Policy: Program Volunteers
7. MRC Policy: PREA
8. DCS Policy 4.9: Employee Disciplinary Actions and Mediation Process DCS Policy 4.1: Employee Background Checks
9. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
10. CS-0687, Background Check History and IV-E Eligibility Checklist
11. MRC YD Pre-Audit Questionnaire responses
12. Background Check History
13. Tennessee Department of Children's Services Database Search Results

Documents (Corrective Action):

1. Employment Annual Questionnaires
2. Updated Questions for New Hires and Promotions

Interviews:

1. Interview with Human Resources Staff

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.317 (a)

PAQ: Agency policy prohibits hiring or promoting anyone who may have contact with residents, and prohibits enlisting the services of any contractor who may have contact with residents, who:

1. Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997);

2. Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or
3. Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section.

The Agency requires the facility does not hire or promote anyone who may have contact with residents, and does not enlist the services of any contractor who may have contact with residents, who has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse.

After corrective action, these questions about previous misconduct are asked during the hiring process. for promotions, and annually. The auditor reviewed applications for hire and annual Employee Questionnaires for verification.

115.317 (b)

PAQ: Agency policy requires the consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

DCS policy states incidents of sexual harassment are considered when determining whether to hire or promote employees.

The MRC Human Resources Director confirmed the facility considers prior incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

115.317 (c)

PAQ: Agency policy requires that before it hires any new employees who may have contact with residents, it (a) conducts criminal background record checks, (b) consults any child abuse registry maintained by the State or locality in which the employee would work; and (c) consistent with Federal, State, and local law, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse

During the past 12 months:

1. The number of persons hired who may have contact with residents who have had criminal background record checks: twelve (12)
2. The percent of persons hired who may have contact with residents who have had criminal background record checks: 100%

DCS policy states the following are included in the criminal background checks:

1. Protocol for Fingerprint Process and Analysis
2. National Sexual Offender Registry Clearance
3. Tennessee Department of Health Abuse Registry Clearance
4. EI-DCS-Provider.Backgroundcheck@tn.gov

5. Drug Offender Registry Clearance
6. TN Felony Offender Database Clearance

Consistent with Federal, State, and local law, Contract Agencies make every effort to contact all prior institutional/facility employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

The MRC Human Resources Director confirmed the facility performs criminal record background checks and considers pertinent civil or administrative adjudications for all newly hired employees who may have contact with residents and all employees, who may have contact with residents, who are being considered for promotions. The facility also consults the Tennessee Department of Children's Services Database

The auditor reviewed Employee Background Checks and Tennessee Department of Children's Services Database Search Results for verification.

115.317 (d)

PAQ: Agency policy requires that a criminal background records check be completed, and applicable child abuse registries consulted before enlisting the services of any contractor who may have contact with residents.

During the past 12 months:

1. The number of contracts for services where criminal background record checks were conducted on all staff covered in the contract who might have contact with residents: 0
2. The percent of contracts for services where criminal background record checks were conducted on all staff covered in the contract who might have contact with residents: N/A

DCS policy states applicant or transferring individual must submit to a complete background check including any waiver granted where applicable. The background check will be completed prior to hire by the appropriate designated DCS/Contract Agency staff and results maintained in the official personnel file. Entities or individuals entering a contract with a covered DCS contract agency shall be subject to this policy only after conditional contract approval.

The MRC Human Resources Director confirmed the facility performs criminal record background checks and considers pertinent civil or administrative adjudications before enlisting the services of any contractor who may have contact with residents. The facility also consults the Tennessee Department of Children's Services Database

115.317 (e)

PAQ: Agency policy requires that either criminal background records checks be conducted at least every five years of current employees and contractors who may have contact with residents or that a system is in place for otherwise capturing such information for current employees.

DCS policy states Contract Agencies conduct annual background checks on all employees who may or may not have direct contact with children or employees who work with sensitive or confidential information. The following is a detailed listing of the documentation and background checks that must be completed annually with results maintained in the employee's personnel file:

1. Driving records including validation of current driver license and a check of moving violations records.

2. An Internet Records Clearance The internet records clearance involves a background check of the following:
 - a. Drug Offender Registry Clearance
 - b. TN Felony Offender Database Clearance
 - c. National Sexual Offender Registry Clearance
 - d. Department of Health Abuse Registry Clearance

The auditor reviewed criminal background record checks of current employees for verification.

115.317 (f)

MRC policy states the facility does not hire or promote anyone who may have contact with residents, and does not enlist the services of any contractor who may have contact with residents, who has engaged in abuse sexual in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse.

The MRC Human Resources Director confirmed MRC asks all applicants and employees who may have contact with residents about previous misconduct described in section (a)* in written applications for hiring or promotions, but not in any interviews or written self-evaluations conducted as part of reviews of current employees. MRC also imposes upon employees a continuing affirmative duty to disclose any such previous misconduct.

After corrective action, these questions about previous misconduct are asked during the hiring process. for promotions, and annually. The auditor reviewed applications for hire and annual Employee Questionnaires for verification.

115.317 (g)

PAQ: Agency policy states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

The MRC Human Resources Director confirmed material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination

115.317 (h)

The MRC Human Resources Director confirmed MRC shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work.

Corrective Action

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility exceeds this standard regarding hiring and promotion decisions. New employees and contractors receive an extensive criminal records background check upon hire and annually thereafter. Corrective action was required.

115.317 (f)

Employee questionnaire (hire, evaluations, and promotions). The three questions were added for new hires and promotions and the three questions are asked annually. Documentation was provided to the auditor for verification. Corrective action is complete as of April 27, 2021.

Standard 115.318: Upgrades to facilities and technologies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.318 (a)

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)
☐ Yes ☐ No ☒ NA

115.318 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)
☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC YD Pre-Audit Questionnaire responses

Interview:

1. Interview with the Agency Head Designee (COO)
2. Interview with the Program Director

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):**115.318 (a)**

PAQ: The agency or facility has not acquired a new facility or made a substantial expansion or modification to existing facilities since the last PREA audit.

The COO and Program Director both confirmed the facility would consider the ability to protect residents from sexual abuse when designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities. Also, the agency would consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse.

115.318 (b)

PAQ: The agency or facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since the last PREA audit.

The COO and Program Director both confirmed when installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the agency shall consider how such technology may enhance the agency's ability to protect residents from sexual abuse.

PREA Site Review:

The auditor observed MRC Youth Development does not have a video monitoring system.

Corrective Action

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding upgrades to facilities and technology. No corrective action is required.

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.321 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)
☐ Yes ☐ No ☒ NA

115.321 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☐ Yes ☐ No ☒ NA
- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☐ Yes ☐ No ☒ NA

115.321 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiary or medically appropriate? ☒ Yes ☐ No
- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No
- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? ☒ Yes ☐ No
- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

115.321 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? ☒ Yes ☐ No

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? (N/A if the agency *always* makes a victim advocate from a rape crisis center available to victims.) ☐ Yes ☐ No ☒ NA
- Has the agency documented its efforts to secure services from rape crisis centers? ☒ Yes ☐ No

115.321 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? ☒ Yes ☐ No
- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? ☒ Yes ☐ No

115.321 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating agency follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 14.25: Special Child Protective Services Investigations
3. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. MRC YD Pre-Audit Questionnaire
5. Memorandum of Understanding with Shelby Rape Crisis Center: [Programs & Services - Help | Shelby County, TN - Official Website](#)

Interviews:

1. Interview with the PREA Compliance Manager
2. Interviews with a Random Sample of Staff
3. Interviews with Residents who Reported a Sexual Abuse – N/A
4. SAFE's/SANE's

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.321 (a)

PAQ: MRC is not responsible for conducting administrative or criminal sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct).

DCS is responsible for conducting administrative sexual abuse investigations. DCS investigators work directly with the Memphis Police Department for criminal sexual abuse investigations.

Staff interviewed confirmed they know and understand the agency's protocol for obtaining usable physical evidence if a resident alleges sexual abuse. They acknowledged CPS and local law enforcement are responsible for conducting sexual abuse investigations.

115.321 (b)

MRC is not responsible for conducting any form of criminal or administrative sexual abuse investigations.

115.321 (c)

PAQ: The facility offers all residents who experience sexual abuse access to forensic medical examinations. Forensic medical examinations are offered without financial cost to the victim. Where possible, examinations are conducted by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). When SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations.

During the past 12 months:

1. The number of forensic medical exams conducted: Zero (0)
2. The number of exams performed by SANEs/SAFEs: Zero (0)
3. The number of exams performed by a qualified medical practitioner: Zero (0)

DCS has a statewide network of Rape Crisis Centers to provide residents who experience sexual abuse access to forensic medical examinations. SAFEs and SANEs are available through Shelby County Rape Crisis Center. Services are provided at the Shelby County Rape Crisis Center, Memphis Child Advocacy Center, and Le Bonheur Children's Hospital.

115.321 (d)

PAQ: MRC makes a victim advocate from a rape crisis center available to the victim, in person or by other means.

The facility has a Memorandum of Understanding with Shelby Rape Crisis Center for victim advocate services. The auditor confirmed availability of the services through a telephone interview and reviewing the Memorandum of Understanding. Additionally, the PREA Compliance Manager confirmed Shelby Rape Crisis Center would provide a qualified victim advocate. There were no residents who reported a sexual abuse present during the onsite audit.

115.321 (e)

PAQ: If requested by the victim, a victim advocate, or qualified agency staff member, or qualified community-based organization staff member accompanies and supports the victim through the forensic medical examination process and investigatory interviews and provides emotional support, crisis intervention, information, and referrals.

The PREA Compliance Manager confirmed Shelby Rape Crisis Center would provide a qualified victim advocate. There were no residents who reported a sexual abuse present during the onsite audit.

115.321 (f)

PAQ: MRC is not responsible for administrative or criminal investigating allegations of sexual abuse and relies on another agency to conduct these investigations. DCS policy outlines they are the responsible agency and they follow the requirements of paragraphs §115.321 (a) through (e) of the standards.

The auditor reviewed DCS Policy 14.25 Special Child Protective Services Investigations for verification.

Corrective Action

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding evidence protocol and forensic medical examinations. No corrective action is required.

Standard 115.322: Policies to ensure referrals of allegations for investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.322 (a)

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? ☒ Yes ☐ No
- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? ☒ Yes ☐ No

115.322 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No
- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No
- Does the agency document all such referrals? ☒ Yes ☐ No

115.322 (c)

- If a separate entity is responsible for conducting criminal investigations, does the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for criminal investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 14.25: Special Child Protective Services Investigations
3. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. MRC YD Pre-Audit Questionnaire responses

Interview:

Interview with the Agency Head Designee (COO)

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.322 (a)

PAQ: MRC ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.

In the past 12 months:

1. The number of allegations of sexual abuse and sexual harassment that were received: Zero (0)
2. The number of allegations resulting in an administrative investigation: N/A
3. The number of allegations referred for criminal investigation: N/A
4. Referring to allegations received in the past 12 months, all administrative and/or criminal investigations were completed: N/A

DCS policy ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse, sexual assault, sexual misconduct, and sexual harassment. All incidents are documented on the Tennessee Family and Child Tracking System (TFACTS). The agency head designee stated MRC ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. He stated DCS is responsible for all investigations and local law enforcement is involved for criminal investigations.

115.322 (b)

PAQ: MRC has a policy that requires that allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, including the agency if it conducts its own investigations, unless the allegation does not involve potentially criminal behavior. The agency's policy regarding the referral of allegations of sexual abuse or sexual harassment for a criminal investigation is published on the agency website. The agency documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigation.

The DCS policy requires that all allegations of sexual abuse or sexual harassment be referred for investigation to DCS. All incidents are documented on the Tennessee Family and Child Tracking System (TFACTS). The policy regarding the referral of allegations of sexual abuse or sexual harassment for a criminal investigation was not previously published on the agency's website.

115.322 (c)

DCS policy describes the responsibilities of both the MRC and DCS.

The auditor reviewed the published policy and verified the policy describes investigative responsibilities of both the agency and DCS.

115.322 (d)

Any State entity responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations.

The Tennessee Department of Children's Services (DCS) has policy governing the conduct of sexual abuse and sexual harassment investigations. The auditor reviewed DCS Policy 14.25 Special Child Protective Services Investigations and DCS Policy 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA for verification.

115.322 (e)

Any Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations.

There is no Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment.

Corrective Action

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding policies to ensure referrals of allegations for investigations. Corrective action was required.

115.322 (b)

"The agency shall have in place a policy to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations unless the allegation does not involve potentially criminal behavior. The agency shall publish such policy on its website or, if it does not have one, make the policy available through other means. The agency shall document all such referrals."

The agency added a link to DCS Policy 18.8 on the website. The auditor reviewed the website for verification. Corrective action is complete.

TRAINING AND EDUCATION

Standard 115.331: Employee training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.331 (a)

- Does the agency train all employees who may have contact with residents on its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on the right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on the dynamics of sexual abuse and sexual harassment in juvenile facilities? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on the common reactions of juvenile victims of sexual abuse and sexual harassment? ☐ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to avoid inappropriate relationships with residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities?
☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on relevant laws regarding the applicable age of consent? ☒ Yes ☐ No

115.331 (b)

- Is such training tailored to the unique needs and attributes of residents of juvenile facilities?
☒ Yes ☐ No
- Is such training tailored to the gender of the residents at the employee's facility? ☒ Yes ☐ No
- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No

115.331 (c)

- Have all current employees who may have contact with residents received such training?
☒ Yes ☐ No
- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No
- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

115.331 (d)

- Does the agency document, through employee signature or electronic verification, that employees understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. MRC YD Pre-Audit Questionnaire responses
4. Required Training Chart for all DCS Staff
5. PREA Training PowerPoints
6. Form CS-0940 Employee/Volunteer/Contractor Acknowledgement and Notification of Prison Rape Elimination Act (PREA)

Interview:

1. Interview with a Random Sample of Staff

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):**115.331 (a)**

PAQ: MRC trains all employees who may have contact with residents on the eleven (11) required topics.

All MRC employees who have contact with residents complete training on:

(1) Its zero-tolerance policy for sexual abuse and sexual harassment; (2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; (3) Residents' right to be free from sexual abuse and sexual harassment; (4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment; (5) The dynamics of sexual abuse and sexual harassment in juvenile facilities; (6) The common reactions of juvenile victims of sexual abuse and sexual harassment; (7) How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents; (8) How to avoid inappropriate relationships with residents; (9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; (10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities; and (11) Relevant laws regarding the applicable age of consent.

Staff interviewed confirmed they have received training on the eleven (11) PREA topics in standard 115.331 when hired and annually thereafter. The auditor reviewed staff training records for verification.

115.331 (b)

PAQ: Training is tailored to the unique needs and attributes and gender of the residents at the facility. Employees who are reassigned from facilities housing the opposite gender are given additional training.

Both MRC facilities have female and male residents.

The auditor reviewed staff training records for verification.

115.331 (c)

PAQ: The number of staff currently employed by the facility, who may have contact with residents, who were trained or retrained on PREA requirements: 15

The percent of staff currently employed by the facility, who may have contact with residents, who were trained or retrained on PREA requirements: 100%

DCS policy states all Agency employees receive training during orientation and through annual refresher training thereafter.

The auditor reviewed the PREA training curriculum and staff training records for verification.

115.331 (d)

PAQ: The agency documents that employees who may have contact with residents understand the training they have received through employee signature or electronic verification.

DCS policy states all Agency employees, volunteers and contractors are required to sign form CS-0940, Employee Acknowledgement and Notification of Prison Rape Elimination Act (PREA) to acknowledge they have read the DCS zero-tolerance policy and understand the training they have received.

The auditor reviewed employee acknowledgement forms and staff training records for verification.

Corrective Action

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility exceeds this standard regarding employee training. Employees are trained annually. No corrective action is required.

Standard 115.332: Volunteer and contractor training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.332 (a)

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures? ☒ Yes ☐ No

115.332 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)? ☒ Yes ☐ No

115.332 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
1. MRC Policy: Program Volunteers
2. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. MRC YD Pre-Audit Questionnaire responses
4. Form CS-0940 Employee/Volunteer/Contractor Acknowledgement and Notification of Prison Rape Elimination Act (PREA)

Interviews:

1. Interviews with Volunteers who have Contact with Residents – N/A

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.332 (a)

PAQ: All volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response policies and procedures.

1. The number of volunteers and contractors, who have contact with residents, who have been trained in agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response: Zero (0)
2. The percent of volunteers and contractors, who have contact with residents, who have been trained in agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response: N/A

DCS policy states all Agency volunteers that have direct contact with children/youth receive training during orientation and annual refresher training thereafter.

The facility does not use the services of volunteers or contractors.

115.332 (b)

PAQ: The level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents, but all volunteers and contractors who have contact with residents shall be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

DCS policy states medical and mental health care practitioners also receive the training mandated for employees under PREA Standards § 115.331 or for contractors and volunteers under PREA Standards § 115.332, depending upon the practitioner's status at the facilities.

The facility does not use the services of volunteers or contractors.

115.332 (c)

PAQ: The agency maintains documentation confirming that volunteers and contractors understand the training they have received.

DCS policy states all Agency employees, volunteers and contractors are required to sign form CS-0940, Employee Acknowledgement and Notification of Prison Rape Elimination Act (PREA) to acknowledge they have read the DCS zero-tolerance policy and understand the training they have received.

The facility does not use the services of volunteers or contractors.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding volunteer and contractor training. No corrective action is required.

Standard 115.333: Resident education**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report****115.333 (a)**

- During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No
- Is this information presented in an age-appropriate fashion? ☒ Yes ☐ No

115.333 (b)

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No
- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.333 (c)

- Have all residents received the comprehensive education referenced in 115.333(b)?
☒ Yes ☐ No
- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility?
☒ Yes ☐ No

115.333 (d)

- Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Are deaf? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills? ☒ Yes ☐ No

115.333 (e)

- Does the agency maintain documentation of resident participation in these education sessions?
☒ Yes ☐ No

115.333 (f)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: Addressing Barriers to Treatment
2. MRC Policy: Deaf and Hard of Hearing Patients
3. MRC Policy: PREA
4. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
5. MRC YD Pre-Audit Questionnaire responses
6. Directory of Interpreters and Translators - Compiled by the Mental Health Association of Middle Tennessee
7. DCS form CS-0939, Youth Acknowledgment and Notification of Prison Rape Elimination Act (PREA)
8. Resident Handbook
9. Pamphlet - "Your Right to be Safe from Sexual Abuse and Assault – A Guide for Youth."
10. Special Education Teacher's Certification
11. PREA Video

Interviews:

1. Interview with Intake Staff
2. Interviews with a Random Sample of Residents

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.333 (a)

PAQ: Residents receive information at time of intake about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. This information is provided in an age appropriate fashion. Of residents admitted during the past 12 months: The number who were given this information at intake: 43

The percent who were given this information at intake: 100%

DCS policy states during the intake process, children/youth receive information explaining, in an age appropriate fashion, the Agency's zero tolerance policy regarding sexual abuse/assault/misconduct/harassment and how to report incidents or suspicions of sexual abuse or sexual harassment.

The Intake Staff confirmed residents are educated on the facility's zero-tolerance policy on sexual abuse and sexual harassment and how to report during intake. Written and verbal information on PREA is provided and explained to all residents within forty-eight (48) hours of intake. Residents interviewed confirmed they were informed of their right not to be sexually abused and sexually harassed, how to report, and their right not to be punished for reporting, during the intake process. They confirmed they received information about the facility's rules against sexual abuse.

The auditor reviewed intake records of residents entering the facility in the past 12 months and residents interviewed for verification. This information is documented with the Youth Acknowledgement of PREA. The auditor also reviewed relevant education materials including resident handbooks, pamphlets, and the "End Silence" Youth Training Booklets.

115.333 (b)

PAQ: Of residents admitted during the past 12 months:

1. The number who received such education within 10 days of intake: 43
2. The percent who were given this information within 10 days of intake: 100%

DCS Policy states written and verbal information on PREA is provided and explained to children/youth within forty-eight (48) hours of arrival at a YDC/Agency and includes, but is not limited to:

1. DCS' zero-tolerance policy regarding PREA;
2. Prevention/Intervention;
3. Self-protection and how to avoid risk situations;
4. Consequences for engaging in any type of sexual activity while at the facility;
5. How to safely report sexual abuse such as:
 - a. Reporting the abuse incident directly to DCS Child Abuse Hotline at: 1-877 237-0004.
 - b. Reporting the abuse incident to YDC/Agency personnel (e.g., Superintendent, Director, nurse, line staff, therapist, security personnel, teacher, or physician).
 - c. Filing a formal grievance as outlined in DCS policy 24.5-DOE Youth Grievance Procedures for youth in a YDC or as outlined in the Contract Provider Manual for children/youth in contract agency facilities. The YDC/Agency does not require the child/youth to use any informal grievance process in an attempt to resolve with staff an alleged incident of sexual abuse
 - d. Reporting the abuse incident to their John L. Attorney or Guardian ad Litem.
6. How to obtain medical and mental health treatment and counseling

The Intake Staff confirmed MRC ensures that residents are educated regarding their rights to be free from sexual abuse and sexual harassment, and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents by providing the information in various educational formats and requiring the residents to sign an acknowledgment form stating they understand then information. She confirmed residents are made aware of these rights within forty-eight (48) hours after intake. Residents interviewed confirmed they were informed of their right not to be sexually abused and sexually harassed, how to report, and their right not to be punished for reporting, during the intake process. Residents stated they received the information on their first or second day at the facility. They also confirmed they received information about the facility's rules against sexual abuse and harassment.

The auditor reviewed intake records of residents entering the facility in the past 12 months and residents interviewed for verification. This information is documented with the Youth Acknowledgement of PREA. The auditor also reviewed relevant education materials including resident handbooks, pamphlets, and the "End Silence" Youth Training Booklets.

115.333 (c)

PAQ: All residents were educated within 10 days of intake.

DCS policy requires that written and verbal information on PREA is provided and explained to children/youth within forty-eight (48) hours of arrival at the Agency.

The Intake Staff confirmed all residents are educated on the facility's zero-tolerance policy on sexual abuse and sexual harassment regardless if they are transferred from other facilities.

The auditor reviewed intake records of residents entering the facility in the past 12 months and residents interviewed for verification.

115.333 (d)

PAQ: The agency shall provide resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills.

DCS policy states appropriate provisions are made as necessary for children/youth who are limited English proficient, have disabilities (including those who are deaf or hard of hearing, those who are blind or have low vision), and those with low intellectual, psychiatric, or speech disabilities.

Policy states appropriate provisions are made as necessary for children/youth who are limited English proficient. Individuals with limited English proficiency requesting information from our facility or applying for our services shall have access to a "Language Identification Flashcard" for the purpose of communicating what language, they speak. MRC has on site bilingual material and provides interpreters on an as needed basis.

MRC policy states in the event Memphis Recovery Centers admits or assesses a deaf or hard of hearing individual Memphis Recovery Centers shall take reasonable efforts and within the limits of its resources to provide

4. Intake screening and counseling personnel who are knowledgeable in issues affecting evaluation, psychosocial development, and impacts of deafness/hard of hearing on individuals and families;
5. A sign language interpreter for patients whose primary means of communication is through manual communication; and
6. Telecommunication device for the deaf (TDD) access or relay system for access

115.333 (e)

PAQ: The agency maintains documentation of resident participation in PREA education sessions.

DCS policy states all residents are required to sign DCS form CS-0939, Youth Acknowledgment and Notification of Prison Rape Elimination Act (PREA) to acknowledge they have been notified and informed of PREA and on how to report incidents of sexual abuse/assault/misconduct/harassment.

The auditor reviewed youth acknowledgment forms of residents entering the facility in the past 12 months and residents interviewed for verification.

115.333 (f)

PAQ: The agency ensures that key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats.

The auditor reviewed the resident posters and pamphlets available in English and Spanish.

During the site review the auditor observed PREA posters are placed prominently in areas of the facility that are easily accessible by the residents.

Corrective Action

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding resident education. No corrective action is required.

Standard 115.334: Specialized training: Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.334 (a)

- In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)
☐ Yes ☐ No ☒ NA

115.334 (b)

- Does this specialized training include techniques for interviewing juvenile sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☐ Yes ☐ No ☒ NA
- Does this specialized training include proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☐ Yes ☐ No ☒ NA
- Does this specialized training include sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☐ Yes ☐ No ☒ NA
- Does this specialized training include the criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)
☐ Yes ☐ No ☒ NA

115.334 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)
☐ Yes ☐ No ☒ NA

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 5.2: Professional Development and Training Requirements
3. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREAMDHS DYS Pre-Audit Questionnaire responses
4. MRC YD Pre-Audit Questionnaire responses

MRC does not conduct any form of administrative or criminal sexual abuse investigations. Investigators are employed and trained by DCS. DCS investigators receive specialized training from the Tennessee Bureau of Investigations (TBI) and National Institute of Corrections (NIC) online training in sexual abuse investigations involving juveniles.

The DCS Special Investigators Unit Training Curriculum includes:

(1) What is PREA; (2) Confined Settings and Sexual Abuse Investigations; (3) Receiving a Referral for a Sexual Abuse Investigation in a Confined Setting; (4) Gathering Information during a Sexual Abuse Investigation in a Confined Setting; (5) Conducting a Sexual Abuse Investigation within a Confined Setting; (6) Interviewing Juvenile Sexual Abuse Victims; (7) Sexual Abuse Evidence Collection in

Confinement Settings; (8) False Allegations; (9) Recanting Information; (10) Witnessing Sexual Abuse; (11) Substantiating a Case for Prosecution Referral; (12) Miranda Warning; and (13) Garrity Warning

Corrective Action

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding specialized training: investigations. No corrective action is required.

Standard 115.335: Specialized training: Medical and mental health care

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.335 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
☒ Yes ☐ No ☐ NA
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA
- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
☒ Yes ☐ No ☐ NA

115.335 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency medical staff at the facility do not conduct forensic exams or the agency does not employ medical staff.)
☐ Yes ☐ No ☒ NA

115.335 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
☒ Yes ☐ No ☐ NA
- Do medical and mental health care practitioners contracted by or volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. Counselor Procedure Manual
4. Form CS-0940 Employee/Volunteer/Contractor Acknowledgement and Notification of Prison Rape Elimination Act (PREA)
5. Specialized PREA Training for Medical and Mental Health Care Standards Curriculum
6. MRC YD Pre-Audit Questionnaire responses

Documents (Corrective Action):

1. Training Records - Specialized PREA Training for Medical and Mental Health Care

Interviews:

1. Interviews with Medical and Mental Health Practitioners

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):**115.335 (a)**

PAQ: The agency has a policy related to the training of medical and mental health practitioners who work regularly in its facilities.

1. The number of all medical and mental health care practitioners who work regularly at this facility who received the training: 3

Memphis Recovery Centers will ensure that all full and part time medical and mental health care practitioners who work regularly in its facilities receive training. This training shall include:

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

Interviews with medical and mental health practitioners confirmed they have not received the specialized training topics regarding sexual abuse and sexual harassment.

The auditor reviewed the Specialized PREA Training for Medical and Mental Health Care Standards training records.

115.335 (b)

PAQ: MRC does not employ medical staff that conduct forensic exams. Forensic medical examinations are performed offsite.

Interviews with medical and mental health practitioners confirmed forensic medical examinations are not conducted at MRC.

115.335 (c)

PAQ: The agency maintains documentation showing that medical and mental health practitioners have completed the required training.

The auditor reviewed the Specialized PREA Training for Medical and Mental Health Care Standards Acknowledgement.

115.335 (d)

DCS policy states medical and mental health care practitioners also receive the training mandated for employees under PREA Standards § 115.331 or for contractors and volunteers under PREA Standards § 115.332, depending upon the practitioner's status at the facilities.

The facility does not use the services of volunteers or contractors.

The auditor reviewed training logs of medical and mental health care practitioners to ensure they received the training for employees and contractors/volunteers (depending on their status) in the referenced standards.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding specialized training for medical and mental health care. Corrective action was required.

115.335 (a)

Memphis Recovery Centers will ensure that all full and part time medical and mental health care practitioners who work regularly in its facilities receive training to include:

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

Specialized training for medical and mental health staff was provided. The auditor reviewed training records for verification. Corrective action is complete as of March 1, 2021.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.341 (a)

- Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident? ☒ Yes ☐ No
- Does the agency also obtain this information periodically throughout a resident's confinement? ☒ Yes ☐ No

115.341 (b)

- Are all PREA screening assessments conducted using an objective screening instrument? ☒ Yes ☐ No

115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (1) Prior sexual victimization or abusiveness? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (3) Current charges and offense history? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (4) Age? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (5) Level of emotional and cognitive development? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (6) Physical size and stature? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (7) Mental illness or mental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (8) Intellectual or developmental disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (9) Physical disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (10) The residents' own perception of vulnerability? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? ☒ Yes ☐ No

115.341 (d)

- Is this information ascertained through conversations with the resident during the intake process and medical mental health screenings? ☒ Yes ☐ No
- Is this information ascertained during classification assessments? ☒ Yes ☐ No
- Is this information ascertained by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files? ☒ Yes ☐ No

115.341 (e)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. DCS form CS-0946 Assessment, Checklist, and Protocol for Behavior and Risk for Victimization
4. MRC YD Pre-Audit Questionnaire responses

Documents (Corrective Action):

1. DCS form CS-1237, Safe Housing Re-Assessments\

Interviews:

1. Interview with the PREA Coordinator
2. Interview with the Staff Responsible for Risk Screening
3. Interviews with a Random Sample of Residents

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.341 (a)

PAQ: The agency has a policy that requires screening (upon admission to a facility or transfer to another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents. The policy requires that residents be screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their intake.

In the past 12 months:

1. The number of residents entering the facility (either through intake or transfer) whose length of stay in the facility was for 72 hours or more who were screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their entry into the facility: 43
2. The percent of residents entering the facility (either through intake or transfer) whose length of stay in the facility was for 72 hours or more who were screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their entry into the facility: 100%

The policy requires that a resident's risk level be reassessed periodically throughout their confinement.

During the intake process, DCS form CS-0946, Prison Rape Elimination Act (PREA) Risk Assessment is administered to all children/youth within seventy-two (72) hours of admission to an Agency.

Once the risk assessment is completed, DCS form CS-1236, Safe Housing Assessment, is used to determine the appropriate housing assignment for the child/youth placed in a congregate care setting.

DCS form CS-1237, Safe Housing Re-Assessment, is completed for children/youth in a congregate care setting at the following time intervals:

1. Every ninety (90) days while in the congregate care setting;
2. Within two (2) days of any occurrence that would require a room assignment change; and
3. At least seven (7) days prior to a transfer to another congregate care setting.

The auditor reviewed completed DCS form CS-0946 Assessment, Checklist, and Protocol for Behavior and Risk for Victimization and DCS form CS-1237, Safe Housing Re-Assessment examples for verification.

The Staff Responsible for Risk Screening confirmed she screens residents upon admission to the facility or transfer from another facility for risk of sexual abuse victimization or sexual abusiveness toward other residents. She stated she screens residents for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their intake. The information is ascertained through conversations with residents during intake and reviewing any relevant court records. Resident's risk levels will be reassessed every three months. Corrective action is required for resident risk reassessments.

Residents interviewed confirmed when they first came to the facility, they were asked questions like whether they have ever been sexually abused, whether they identify with being gay, bisexual or transgender, whether they have any disabilities, and whether they think they might be in danger of sexual abuse at the facility. They stated they were asked these questions the first or second day at the facility.

115.341 (b)

PAQ: Risk assessment is conducted using an objective screening instrument. Such assessments shall be conducted using an objective screening instrument.

115.341 (c)

At a minimum, the agency shall attempt to ascertain information about:

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

The Staff Responsible for Risk Screening confirmed the initial risk screening considers all aspects required by the standard.

115.341 (d) This information shall be ascertained through conversations with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files.

The Staff Responsible for Risk Screening confirmed the information is ascertained through conversations with residents during intake, medical and mental health screenings, and reviewing any relevant court records.

115.341 (e) The agency shall implement appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents.

The PREA Coordinator and Staff Responsible for Risk Screening confirmed the agency has outlined who can have access to a resident's risk assessment within the facility, in order to protect sensitive information from exploitation. The individuals include the PREA Coordinator, PREA Compliance Manager, and counselors.

Corrective Action

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding obtaining information from residents. Corrective action was required.

115.341 (a)

DCS form CS-1237, Safe Housing Re-Assessment, was completed for all residents who have been at MRC for three months. Reassessments were also required for an additional three months to show the standard provision is fully in practice. The auditor reviewed Safe Housing Re-Assessments for verification. Corrective action is complete as of March 11, 2021.

Standard 115.342: Use of screening information

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.342 (a)

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments? ☒ Yes ☐ No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments? ☒ Yes ☐ No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments? ☒ Yes ☐ No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments? ☒ Yes ☐ No
- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments? ☒ Yes ☐ No

115.342 (b)

- Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA
- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA
- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA
- Do residents in isolation receive daily visits from a medical or mental health care clinician? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA
- Do residents in isolation also have access to other programs and work opportunities to the extent possible? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

115.342 (c)

- Does the agency always refrain from placing lesbian, gay, and bisexual (LGB) residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No
- Does the agency always refrain from placing transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No
- Does the agency always refrain from placing intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No
- Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex (LGBTI) identification or status as an indicator or likelihood of being sexually abusive? ☒ Yes ☐ No

115.342 (d)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider, on a case-by-case basis, whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? ☒ Yes ☐ No
- When making housing or other program assignments for transgender or intersex residents, does the agency consider, on a case-by-case basis, whether a placement would ensure the

resident's health and safety, and whether a placement would present management or security problems? ☒ Yes ☐ No

115.342 (e)

- Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident? ☒ Yes ☐ No

115.342 (f)

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? ☒ Yes ☐ No

115.342 (g)

- Are transgender and intersex residents given the opportunity to shower separately from other residents? ☒ Yes ☐ No

115.342 (h)

- If a resident is isolated pursuant to provision (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA
- If a resident is isolated pursuant to provision (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

115.342 (i)

- In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. DCS Policy 20.20 Guidelines for Managing Children/Youth in DCS Custody Related
4. to Sexual Orientation, Gender Identity and Expression
5. DCS form CS-0946 Assessment, Checklist, and Protocol for Behavior and Risk for Victimization
6. DCS form CS-1236, Safe Housing Assessment
7. MRC YD Pre-Audit Questionnaire responses

Interviews:

1. Interview with the PREA Coordinator
2. Interview with the PREA Compliance Manager
3. Interview with Staff Responsible for Risk Screening
4. Interview with the Facility Director
5. Interview with Staff who Supervise Residents in Isolation – N/A
6. Interviews with Medical and Mental Health Practitioners
7. Interviews with Transgendered/Intersex/Gay/Lesbian/Bisexual Residents – N/A
8. Residents in Isolation (for risk of sexual victimization/who allege to have suffered sexual abuse) – N/A

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.342 (a)

PAQ: The agency/facility uses information from the risk screening required by §115.341 to inform housing, bed, work, education, and program assignments with the goal of keeping all residents safe and free from sexual abuse.

DCS Policy states during the intake process, DCS form CS-0946, Prison Rape Elimination Act (PREA) Risk Assessment is administered to all children/youth within seventy-two (72) hours of admission to an Agency. Once the risk assessment is completed, DCS form CS-1236, Safe Housing Assessment, is used to determine the appropriate housing assignment for the child/youth placed in a congregate care setting.

Designated staff develops appropriate treatment interventions that include further assessments or screenings by a mental health professional for identified children/youth prior to assigning the child/youth to a program, education, or work to decrease the risk of sexual victimization/perpetration.

The PREA Compliance Manager and Staff Responsible for Risk Screening confirmed the facility uses information from the risk screening during intake to keep residents safe and free from sexual abuse and sexual harassment by determining housing assignments and programming.

115.342 (b)

PAQ: The facility has a policy that residents at risk of sexual victimization may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged. The facility policy requires that residents at risk of sexual victimization who are placed in isolation have access to legally required educational programming, special education services, and daily large-muscle exercise. In the past 12 months:

1. The number of residents at risk of sexual victimization who were placed in isolation: 0
2. The number of residents at risk of sexual victimization who were placed in isolation who have been denied daily access to large muscle exercise, and/or legally required education, or special education services: 0
3. The average period of time residents at risk of sexual victimization who were held in isolation to protect them from sexual victimization: N/A

The Program Director confirmed there is no use of isolation.

115.342 (c)

PAQ: The facility prohibits placing lesbian, gay, bisexual, transgender, or intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status. The facility prohibits considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

DCS policy states the Agency will use all pertinent information gathered during the assessment process and subsequently, including the child/youth's stated preference to make housing, bed, program, education, and work assignments for youth with the goal of keeping all residents safe and free from sexual abuse, physical abuse, psychological harm, and harassment, and whether the placement would present management or security problems. Youth must not be prohibited from having a roommate based on a youth's actual or perceived sexual orientation. If a youth is fearful of rooming with another person, he or she will be provided a single room, if available. This assignment will be made in accordance with classification procedure and facility safety and security needs.

The PREA Coordinator and PREA Compliance Manager confirmed gay, bisexual, transgender, or intersex residents are not placed in particular housing, bed, or other assignments solely on the basis of such identification or status, nor does the facility consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

Three (3) residents who identified as bisexual confirmed they are not placed in particular housing, bed, or other assignments solely on the basis of such identification or status.

115.342 (d)

PAQ: The agency or facility makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis.

DCS policy states transgender youth shall not automatically be placed according to their birth sex. DCS, contract providers (as applicable) and other professionals working with the youth will discuss the placement needs in an internal discussion to determine what placement is the best interest placement

based on the needs of the youth and available placement options. The most appropriate placement should be based on the child/youth's gender identity taking into consideration any management or security barriers associated with the proposed placement. Each placement shall be made on an individualized basis to best meet the needs of the child/youth.

The PREA Compliance Manager confirmed housing and programming assignments for transgendered and intersex residents are considered on a case-by-case basis whether the placement would ensure the resident's health and safety, and whether the placement would present management or security problems.

115.342 (e)

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

DCS policy placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident.

The PREA Compliance Manager and Staff Responsible for Risk Screening confirmed placement and programming assignments are reassessed at least twice each year to review any threats to safety experienced by the resident.

115.342 (f)

PAQ: A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration.

DCS policy states with respect to his or her own safety, a LGBTI child/youth's own views will be given serious consideration.

The PREA Compliance Manager and Staff Responsible for Risk Screening confirmed a transgender or intersex resident's own views with respect to his or her own safety is given serious consideration.

115.342 (g)

PAQ: Transgender and intersex residents shall be given the opportunity to shower separately from other residents.

DCS policy states transgender youth must be given the opportunity to shower separately from other youth and they must be provided safety and privacy when dressing and undressing and using the bathroom.

The PREA Compliance Manager and Staff Responsible for Risk Screening confirmed transgender and intersex residents are given the opportunity to shower separately from other residents. All residents shower separately.

115.342 (h)

PAQ: From a review of case files of residents at risk of sexual victimization who were held in isolation in the past 12 months, the number of case files that include BOTH:

1. A statement of the basis for facility's concern for the resident's safety, and
2. The reason or reasons why alternative means of separation cannot be arranged: N/A

If a resident is isolated pursuant to paragraph (b) of this section, the facility shall clearly document:

- (1) The basis for the facility's concern for the resident's safety; and
- (2) The reason why no alternative means of separation can be arranged.

MRC does not use isolation.

115.342 (i)

PAQ: If a resident at risk of sexual victimization is held in isolation, the facility affords each such resident a review every 30 days to determine whether there is a continuing need for separation from the general population.

MRC does not use isolation.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding use of screening information. No corrective action is required.

REPORTING

Standard 115.351: Resident reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.351 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

115.351 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No
- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No
- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment? (N/A if the facility *never* houses residents detained solely for civil immigration purposes.) ☒ Yes ☐ No ☐ NA

115.351 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? ☒ Yes ☐ No
- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.351 (d)

- Does the facility provide residents with access to tools necessary to make a written report? ☒ Yes ☐ No

- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. MRC Policy: Child Abuse Reporting
3. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. DCS Policy: 24.5-DOE Youth Grievance Procedures
5. MRC YD Pre-Audit Questionnaire responses
6. Duty to Report - Tennessee Code Annotated 37-1-403 and 37-1-605
7. Form CS-0072 Youth Grievance
8. Counselor Procedure Manual
9. Resident Handbook
10. Tennessee Child Abuse Website: <https://www.tn.gov/dcs/program-areas/child-safety/reporting/child-abuse.html>
11. DCS Pamphlet - "A Teen's Guide to Reporting Abuse" (English and Spanish)

Interviews:

1. Interview with the PREA Compliance Manager
2. Interviews with a Random Sample of Staff
3. Interviews with a Random Sample of Residents
4. Interviews with Residents who Reported a Sexual Abuse – N/A

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.351 (a)

PAQ: The agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about: Sexual abuse or sexual harassment; Retaliation by other residents or staff for reporting sexual abuse and sexual harassment; AND Staff neglect or violation of responsibilities that may have contributed to such incidents.

MRC shall provide multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.

DCS policy states how to safely report sexual abuse such as:

1. Reporting the abuse incident directly to DCS Child Abuse Hotline at: 1-877 237-0004.
2. Reporting the abuse incident to Agency personnel (e.g., Superintendent, Director, nurse, line staff, therapist, security personnel, teacher, or physician).
3. Filing a formal grievance as outlined in DCS policy 24.5-DOE Youth Grievance Procedures for youth in a YDC or as outlined in the Contract Provider Manual for children/youth in contract agency facilities. The YDC/Agency does not require the child/youth to use any informal grievance process in an attempt to resolve with staff an alleged incident of sexual abuse.
4. Reporting the abuse incident to their John L. Attorney or Guardian ad Litem.

Staff interviews confirmed residents can privately report sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, or staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment by calling the DCS hotline number. Residents stated they would report sexual abuse or sexual harassment that happened to them or someone else by telling staff, calling the hotline, or writing a letter.

115.351 (b)

PAQ: The agency provides at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency. The agency has a policy requiring residents detained solely for civil immigration purposes be provided information on how to contact relevant consular officials and relevant officials of the Department of Homeland Security.

MRC shall also provide at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of MRC and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. Residents detained solely for civil immigration purposes shall be provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security.

MRC provides information for residents to call the Tennessee Child Abuse Hotline and the Shelby County Rape Crisis Center in the resident handbook.

- Tennessee Child Abuse Hotline: 1-877-237-0004
- Shelby County Rape Crisis Center: 1-901-222-4250
1750 Madison Avenue,
Memphis, Tennessee 38104

The PREA Compliance Manager identified the DCS hotline as one way residents can report sexual abuse or sexual harassment to a public or private entity that is not part of the agency. Calling the DCS hotline enables receipt and immediate transmission of resident reports of sexual abuse or sexual harassment to agency officials and allows the resident to remain anonymous upon request. Residents

stated they would report sexual abuse or sexual harassment that happened to them or someone else by telling staff, calling the hotline, or writing a letter. They also could identify someone that does not work at the facility they could report to.

The auditor observed the resident handbook and posters with information for reporting sexual abuse or sexual harassment.

115.351 (c)

PAQ: The agency has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. Staff are required to document verbal reports. The time frame that staff are required to document verbal reports: By end of shift.

DCS policy says the Duty to Report – Tennessee Code Annotated 37-1-403 and 37-1-605 Pursuant to TCA 37-1-403 and 37-1-605, any person who has knowledge of or is called upon to render aid to any child/youth who is being sexually abused, sexually assaulted, or sexually harassed has the duty to report such abuse. All allegations of sexual abuse are reported to the DCS Child Abuse Hotline 1-877-237-0004. Failure to comply with “duty to report” requirements result in disciplinary action up to and including termination and/or criminal charges. Refer to DCS policy 4.9 Employee Disciplinary Actions and Mediation Process. All Agency staff report immediately and according to policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in an Agency facility, whether or not it is a part of the agency; retaliation against children/youth or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

Interviews with staff confirmed when a resident alleges sexual abuse or sexual harassment, he can do so verbally, in writing, anonymously and through third parties. Staff stated they document verbal reports. Most said immediately, but all stated they would document as soon as possible. Residents confirmed they can make reports of sexual abuse or sexual harassment either in person or in writing and someone else could make the report for them, so they do not have to give their name.

115.351 (d)

PAQ: The facility provides residents with access to tools to make written reports of sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.

The PREA Compliance Manager confirmed residents can keep pencils and paper to make written reports of sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. The locked grievance box is located at the bottom of the stairs in the administration/school building.

115.351 (e)

PAQ: The agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents.

Staff report to the DCS Child Abuse Hotline at 1-877-237-0004.

Staff interviewed identified the DCS Child Abuse Hotline as a way for them to privately report sexual abuse and sexual harassment of residents. Other answers included reporting to their supervisor.

Corrective Action

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding resident reporting. No corrective action is required.

Standard 115.352: Exhaustion of administrative remedies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.352 (a)

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse. ☒ Yes ☐ No

115.352 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 14.15: Reporting False Allegations of Child Sexual Abuse
3. DCS Policy 24.5: DOE Youth Grievance Procedures

4. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
5. MRC YD Pre-Audit Questionnaire responses
6. Duty to Report - Tennessee Code Annotated 37-1-403 and 37-1-605
7. Tennessee Code Annotated 37-1-413
8. Resident Handbook
9. Form CS-0072 Youth Grievance

Interviews:

1. Interviews with Residents who Reported a Sexual Abuse - N/A

Site Review Observations:

Observations during on-site review of physical plant

Findings:

This standard does not apply to MRC. All resident grievances regarding sexual abuse are investigated externally by DCS.

MRC does not have an administrative procedure for dealing with resident grievances regarding sexual abuse. DCS policy allows a resident to file a grievance (such a grievance would be treated as an emergency or urgent situation and would be handled immediately). Residents are not required to nor should they attempt to resolve with staff an alleged incident of sexual abuse. Grievances involving allegations of sexual abuse, sexual assault, misconduct, harassment, or retaliation for reporting such incidents are not required to be and should not be referred to the staff member who is the subject of the complaint.

Residents may report allegations of sexual abuse at any time regardless of when the incident is alleged to have occurred. Residents may get assistance in filing requests for administrative remedies relating to allegations of sexual abuse from third parties, including other residents, staff members, family members, attorneys, and/or outside advocates. Those third parties may also file such requests on behalf of residents. If the resident declines to have third-party assistance in filing a grievance alleging sexual abuse, the resident's decision to decline must be documented

PAQ: In the past 12 months:

The number of grievances that were filed that alleged sexual abuse: Zero (0)

The auditor reviewed the resident handbook to determine that relevant information is provided.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding exhaustion of administrative remedies. No corrective action is required.

Standard 115.353: Resident access to outside confidential support services and legal representation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.353 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making assessable mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No
- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? (N/A if the facility *never* has persons detained solely for civil immigration purposes.) ☒ Yes ☐ No ☐ NA
- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.353 (b)

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? ☒ Yes ☐ No

115.353 (c)

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? ☒ Yes ☐ No
- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☒ Yes ☐ No

115.353 (d)

- Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation? ☒ Yes ☐ No
- Does the facility provide residents with reasonable access to parents or legal guardians? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. MRC YD Pre-Audit Questionnaire responses
4. Memorandum of Understanding with Shelby County Rape Crisis Center
5. Shelby County Rape Crisis Center Mission Statement
6. Duty to Report - Tennessee Code Annotated 37-1-403 and 37-1-605
7. Resident Handbook – Outside Support Services

Interviews:

1. Interview with the PREA Compliance Manager
2. Interview with the Facility Director
3. Interviews with a Random Sample of Residents
4. Interviews with Residents who Reported a Sexual Abuse - N/A

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.353 (a)

PAQ: The facility provides residents access to outside victim advocates for emotional support services related to sexual abuse by:

1. Giving residents (by providing, posting, or otherwise making accessible) mailing addresses and telephone numbers (including toll-free hotline numbers where available) of local, State, or national victim advocacy or rape crisis organizations.
2. Enabling reasonable communication between residents and these organizations, in as confidential a manner as possible.

MRC has a MOU with Shelby County Rape Crisis Center for victim advocates and emotional support services. The auditor reviewed the MOU for verification. The auditor observed contact information for Shelby County Rape Crisis Center is provided to the residents in the resident handbook.

- Shelby County Rape Crisis Center: 1-901-222-4250
1750 Madison Avenue,
Memphis, Tennessee 38104

Residents acknowledged there are services available outside of this facility for dealing with sexual abuse if they ever need it. Most residents knew about the availability of a victim advocate and knew the information was included in their handbooks. The auditor had a handbook available during interviews

with residents. They confirmed they would be able to talk with people from outside services when needed and the call would be private.

115.353 (b)

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

Memphis Recovery Centers shall inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws.

Interviews with residents confirmed most residents were knowledgeable of mandatory reporting rules when having conversations with people from outside services. The auditor explained mandatory reporting to the residents who were less familiar with mandatory reporting rules.

115.353 (c)

PAQ: The agency or facility maintains memoranda of understanding (MOUs) or other agreements with community service providers that are able to provide residents with emotional support services related to sexual abuse. The agency or facility maintains copies of those agreements.

MRC has a MOU with Shelby County Rape Crisis Center for victim advocates and emotional support services. The auditor reviewed the MOU for verification.

115.353 (d)

PAQ: The facility provides residents with reasonable and confidential access to their attorneys or other legal representation. The facility provides residents with reasonable access to parents or legal guardians.

The Program Director and PREA Compliance Manager confirmed the facility would provide residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians.

Residents confirmed the facility allows them to see or talk with their lawyer or another lawyer and they are allowed to talk with that person privately. Residents also confirmed the facility allows them to see or talk with their parents or someone else such as a legal guardian.

Corrective Action

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding resident access to outside support services and legal representation. No corrective action is required.

Standard 115.354: Third-party reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.354 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy: 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. MRC YD Pre-Audit Questionnaire responses
4. Resident Handbook

Documents (Corrective Action):

1. Website Publication for third-part reporting

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.354 (a)

PAQ: The agency or facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment.

Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports. The facility does not distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident. This will be addressed through corrective action.

Corrective Action

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding third-party reporting.

Third party reporting - "The agency shall establish a method to receive third-party reports of sexual abuse and sexual harassment and shall distribute publicly information (website) on how to report sexual abuse and sexual harassment on behalf of a resident."

The agency added the PREA Coordinator's name, email address/link, and telephone number to the website under the heading: third-party reporting. The auditor reviewed the website for verification. Corrective action is complete.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.361 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

115.361 (b)

- Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws? ☒ Yes ☐ No

115.361 (c)

- Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? ☒ Yes ☐ No

115.361 (d)

- Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws? ☒ Yes ☐ No
- Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

115.361 (e)

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office? ☒ Yes ☐ No

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified?
☒ Yes ☐ No
- If an alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? ☒ Yes ☐ No
- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation? ☒ Yes ☐ No

115.361 (f)

- Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. MRC Policy: Child Abuse Reporting
3. DCS Policy 14.25: Special Child Protective Services Investigations DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. MRC YD Pre-Audit Questionnaire responses
5. Duty to Report - Tennessee Code Annotated 37-1-403 and 37-1-605

Interviews:

1. Interview with the PREA Compliance Manager
2. Interview with the Facility Director
3. Interviews with a Random Sample of Staff
4. Interviews with Medical and Mental Health Practitioners

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):**115.361 (a)**

PAQ: The agency requires all staff to report immediately and according to agency policy:

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

DCS policy states all Agency staff report immediately and according to policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a YDC/Agency facility, whether or not it is a part of the agency; retaliation against children/youth or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

MRC policy states the President / CEO or Chief Operating Officer must be notified immediately at 901-272-7751 if an employee is made aware of or suspects abuse or neglect of any patient while at any MRC facility. Appropriate legal and disciplinary action will be taken. In the event the abuse involves a minor, the Department of Children's Services must also be notified immediately at 1-877-237-0004.

Staff confirmed the agency requires all staff to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. They stated they would report to their supervisor and the DCS hotline.

115.361 (b)

PAQ: The agency requires all staff to comply with any applicable mandatory child abuse reporting laws.

Duty to Report – As per Tennessee Code Annotated 37-1-403 and 37-1-605 Pursuant to TCA 37-1-403 and 37-1-605, any person who has knowledge of or is called upon to render aid to any child/youth who is being sexually abused, sexually assaulted or sexually harassed has the duty to report such abuse. In terms of PREA standards, this duty to report includes but is not limited to any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

Staff confirmed PREA training includes how to comply with relevant laws related to mandatory reporting of sexual abuse.

115.361 (c)

PAQ: Apart from reporting to designated supervisors or officials and designated State or local service agencies, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions.

Staff confirmed the agency requires all staff to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. They stated they would report to their supervisor and DCS.

115.361 (d)

Medical and mental health practitioners are required to report sexual abuse to DCS. They are mandated to follow Duty to Report laws. Medical and mental health practitioners are required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality.

Interviews with medical and mental health practitioners confirmed they disclose the limitations of confidentiality and their duty to report at the initiation of services to a resident. They confirmed they are required by law to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment upon learning of it. They reported they have not become aware of such incidents.

115.361 (e)

MRC policy requires that upon receiving any allegation of sexual abuse, the Executive Director or his or her designee shall promptly report the allegation to the alleged victim's parents or legal guardians, unless Memphis Recovery Centers has official documentation showing the parents or legal guardians should not be notified. If the alleged victim is under the guardianship of DCS, the report shall be made to the alleged victim's Family Services Worker instead of the parents or legal guardians. If a juvenile court retains jurisdiction over the alleged victim, the Executive Director or designee shall also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation.

The PREA Compliance Manager confirmed when the facility receives an allegation of sexual abuse the allegation is reported to the DCS Child Abuse Hotline and the victim's legal guardians as appropriate. This notification would usually occur immediately. The Program Director confirmed when the facility receives an allegation of sexual abuse the allegation is reported to the DCS Child Abuse Hotline and the victim's legal guardians as appropriate. This notification would occur immediately upon the allegation being received. If a juvenile court retains jurisdiction over the alleged victim, the Executive Director or DCS shall report the allegation to the juvenile's attorney. All allegations of sexual abuse and sexual harassment are reported to the DCS Special Investigations Unit. MRC does not conduct administrative or criminal investigations.

115.361 (f)

MRC policy requires all allegations of sexual abuse must be reported immediately to the DCS Child Abuse Hotline at 1-877-237-0004. DCS ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse/assault/misconduct/harassment.

The Program Director confirmed all allegations of sexual abuse and sexual harassment (including those from third-party and anonymous sources) are reported directly to designated facility investigators.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding staff and agency reporting duties. No corrective action is required.

Policy suggestion:

115.361 (c) and (d) Policy is not expressly inclusive of the standard provisions.

Standard 115.362: Agency protection duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.362 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 27.40-DOE: Youth Belief of Physical Danger
3. DCS Policy: 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. MRC YD Pre-Audit Questionnaire responses

Interviews:

1. Interview with the Agency Head Designee (COO)
2. Interview with the Facility Director

3. Interviews with a Random Sample of Staff

Site Review Observations:

Observations during on-site review of physical plant

Findings:

PAQ: When the agency or facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident (i.e., it takes some action to assess and implement appropriate protective measures without unreasonable delay).

In the past 12 months:

1. The number of times the agency or facility determined that a resident was subject to substantial risk of imminent sexual abuse: Zero (0)

DCS policy states if a youth believes that a physical attack is imminent, he/she may request assistance from any staff member. If the staff member from whom assistance has been requested is unable to adequately investigate and/or resolve the situation, he/she shall refer the matter and the youth to the shift supervisor. In all cases, the matter shall be investigated immediately. Unless the youth's claim is found to be clearly without merit, corrective/preventive measures shall be taken immediately. Such corrective/preventive measures shall be increased, modified, or discontinued as the threat might dictate.

The most appropriate corrective measures are those interventions which provide protection while being least disruptive to the youth's normal program. Staff may elect to:

1. Discuss the problem with the youths involved to achieve a workable solution;
2. Increase visual supervision and/or the physical closeness of the staff member to the youth;
3. Move the threatened youth or the youth(s) creating the problem to a different housing unit; and
4. Review of program placement.

The COO and Program Director confirmed immediate action would be taken to protect a resident subject to a substantial risk of imminent sexual abuse. These actions would include separating the resident from the potential perpetrator, monitoring closely, and possible transfer to another program or facility. Staff interviewed confirmed they would immediately separate a resident subject to a substantial risk of imminent sexual abuse from a potential perpetrator and provide close observation.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding agency protection duties. No corrective action is required.

Standard 115.363: Reporting to other confinement facilities

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.363 (a)

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? ☒ Yes ☐ No

- Does the head of the facility that received the allegation also notify the appropriate investigative agency? ☒ Yes ☐ No

115.363 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? ☒ Yes ☐ No

115.363 (c)

- Does the agency document that it has provided such notification? ☒ Yes ☐ No

115.363 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy: 1.4 Incident Reporting
3. DCS Policy: 18.8 Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. MRC YD Pre-Audit Questionnaire responses

Interviews:

1. Interview with the Agency Head Designee (COO)
2. Interview with the Facility Director

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.363 (a)

PAQ: The agency has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. The agency's policy also requires that the head of the facility notify the appropriate investigative agency. In the past 12 months, the number of allegations the facility received that a resident was abused while confined at another facility: Zero (0)

DCS policy states if victimization occurred while the child/youth was confined at another congregate care setting, the head of the congregate care setting that received the allegation promptly, within seventy-two hours, notifies the head of the congregate care setting where the alleged abuse occurred and reports the abuse incident directly to DCS Child Abuse Hotline at 1-877 237-0004.

The Program Director confirmed that if the facility receives an allegation from another facility or agency that an incident of sexual abuse or sexual harassment occurred at the facility, the incident would be reported through the DCS. She stated there were no examples of this occurring.

115.363 (b)

PAQ: Agency policy requires that the facility head provides such notification as soon as possible, but no later than 72 hours after receiving the allegation.

DCS policy states the head of the congregate care setting that received the allegation promptly, within seventy-two hours, notifies the head of the congregate care setting where the alleged abuse occurred and reports the abuse incident directly to DCS Child Abuse Hotline at 1-877 237-0004.

115.363 (c)

PAQ: The agency or facility documents that it has provided such notification within 72 hours of receiving the allegation.

DCS policy states all incidents of sexual abuse/assault/misconduct/harassment and rape are documented in appropriate TFACTS incident reporting section as outlined in DCS policy 1.4 Incident Reporting.

115.363 (d)

PAQ: Agency/facility policy requires that allegations received from other facilities/agencies are investigated in accordance with the PREA standards. The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards. In the past 12 months, the number of allegations of sexual abuse the facility received from other facilities: Zero (0)

DCS policy states DCS ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse, sexual assault, sexual misconduct, and sexual harassment.

The COO confirmed DCS and the CEO would be the point of contact. The Program Director confirmed if an allegation is received from another facility or agency that an incident of sexual abuse or harassment occurred in the facility, DCS would conduct the investigation. She stated there are no examples of this occurring.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding reporting to other confinement facilities. No corrective action is required.

Policy Suggestion

115.363 (a) and (b) Policy is not expressly inclusive of the standard provisions.

Standard 115.364: Staff first responder duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.364 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser?
☒ Yes ☐ No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? ☒ Yes ☐ No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No
- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

115.364 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. MRC Policy: Management Alert
3. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. MRC YD Pre-Audit Questionnaire responses
5. DCS Protocol: First Responder Guidelines for Sexual Assaults

Interviews:

1. Interviews with Non-security Staff First Responders
2. Interviews with a Random Sample of Staff

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.364 (a)

PAQ: The agency has a first responder policy for allegations of sexual abuse. The agency policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to:

1. Separate the alleged victim and abuser;
2. Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;
3. If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and
4. If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.

In the past 12 months, the number of allegations that a resident was sexually abused: Zero (0)

Of these allegations, the number of times the first security staff member to respond to the report separated the alleged victim and abuser: Zero (0)

In the past 12 months, the number of allegations where staff were notified within a time period that still allowed for the collection of physical evidence: Zero (0)

DCS policy states upon receiving notice of an incident of sexual abuse by a child/youth, or if an employee witnesses or unexpectedly encounters an assault taking place, the employee:

1. Ensures the child/youth is safe and kept separated from the perpetrator, immediately notify their Supervisor;
2. Ensures child/youth does not change clothes, shower, wash, brush teeth, rinse mouth, eat, drink, or use the toilet until after all physical evidence is obtained in connection with the violation;
3. Secures the incident area and treat it as a crime scene; and
6. Refer to DCS Protocol: First Responder Guidelines for Sexual Assaults for guidelines on responding to sexual assaults.

Interviews with staff confirmed they were knowledgeable of their first responder duties. MRC does not employ security staff.

115.364 (b)

PAQ: Agency policy requires that if the first staff responder is not a security staff member, that responder shall be required to:

1. Request that the alleged victim not take any actions that could destroy physical evidence.
2. Notify security staff.

Of the allegations that a resident was sexually abused made in the past 12 months, the number of times a non-security staff member was the first responder: Zero (0)

MRC does not employ security staff. All staff would respond according to standard provision 115.364(a).

Interviews with staff confirmed they were knowledgeable of their first responder duties. Staff interviewed were knowledgeable of their first responder duties.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding staff first responder duties. No corrective action is required.

Standard 115.365: Coordinated response

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.365 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 14.25: Special Child Protective Services Investigations
3. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. MRC YD Pre-Audit Questionnaire responses
5. DCS Protocol: First Responder Guidelines for Sexual Assaults

Interview:

1. Interview with the Facility Director

Site Review Observation:

Observations during on-site review of physical plant

Findings:

PAQ: The facility has developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership.

DCS policy states in response to an allegation of sexual abuse, the Agency develops a written plan to coordinate actions taken among staff first responders, medical and mental health practitioners, investigators, and Agency leadership.

The DCS Protocol: First Responder Guidelines for Sexual Assaults coordinates actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership.

The Program Director confirmed that after the initial actions of facility first responders and leadership, DCS coordinates the actions among medical and mental health practitioners and investigators. The DCS Protocol: First Responder Guidelines for Sexual Assaults is followed.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding a coordinated response. No corrective action is required.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.366 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? ☒ Yes ☐ No

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. MRC YD Pre-Audit Questionnaire responses

Interview:

1. Interview with the Agency Head Designee (COO)

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):**115.366 (a)**

PAQ: The agency, facility, or any other governmental entity responsible for collective bargaining on the agency's behalf has not entered into or renewed any collective bargaining agreement or other agreement since the last PREA audit.

The COO confirmed MRC has not entered into or renewed any collective bargaining agreements.

115.366 (b)

MRC has not entered into or renewed any collective bargaining agreements.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding preservation of the ability to protect residents from contact with abusers. No corrective action is required.

Standard 115.367: Agency protection against retaliation**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report****115.367 (a)**

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? ☒ Yes ☐ No
- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

115.367 (b)

- Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with

victims, and emotional support services, for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations? ☒ Yes ☐ No

115.367 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: The conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: The conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Any resident disciplinary reports? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Resident housing changes? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Resident program changes? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Negative performance reviews of staff? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Reassignments of staff? ☒ Yes ☐ No
- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

115.367 (d)

- In the case of residents, does such monitoring also include periodic status checks?
☒ Yes ☐ No

115.367 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?
☒ Yes ☐ No

115.367 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. MRC YD Pre-Audit Questionnaire responses

Interviews:

1. Interview with the Agency Head Designee (COO)
2. Interview with the Facility Director
3. Interview with the Designated Staff Member Charged with Monitoring Retaliation (PREA Coordinator)
4. Interview with Residents in Isolation (for risk of sexual victimization/who allege to have suffered sexual abuse) - N/A
5. Interview with Residents who Reported a Sexual Abuse – N/A

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.367 (a)

PAQ: The agency has a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff.

The Agency designates staff member(s) or charges department(s) with monitoring for possible retaliation.

The name(s) of the staff member(s): Jennifer Armstrong

The title(s) of the staff member(s): HR Director

MRC policy states MRC will ensure retaliation by other residents or staff does not occur towards residents or staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations.

115.367 (b)

DCS policy states if any individual involved in a report expresses fear of retaliation, the Agency takes appropriate measures to protect the individual that includes segregated (protective) housing, as applicable, if voluntarily requested by the individual.

The COO stated the facility would protect residents and staff from retaliation for sexual abuse or sexual harassment allegations through housing changes or transfers and removal of alleged abusers. The Program Director stated the facility would make housing changes, transfers, and removal of alleged abusers, and provide emotional support services. The PREA Coordinator stated the role she would play to prevent residents and staff from retaliation for sexual abuse or sexual harassment allegations would be making housing changes or transfers, removal of alleged abusers, and providing emotional support services. She stated the different measures she would take to protect residents and staff from retaliation would be the same. She confirmed she would initiate contact with residents who have reported sexual abuse.

115.367 (c)

PAQ: The agency and/or facility monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff.

The length of time that the agency and/or facility monitors the conduct or treatment: 90 days

The agency/facility acts promptly to remedy any such retaliation.

The agency/facility continues such monitoring beyond 90 days if the initial monitoring indicates a continuing need.

The number of times an incident of retaliation occurred in the past 12 months: Zero (0)

DCS policy states for a period of ninety (90) days following a report, the agency monitors the treatment of child/youth or staff that made a report and the child/youth that were reported to be abused to identify attempts at retaliation or negative consequences and act immediately to remedy any such actions.

Monitoring should include, but is not limited to:

- Child/youth disciplinary reports, housing, or program changes;
- Negative performance reviews or staff reassignments; and
- Periodic status checks of children/youth.

The Agency continues monitoring beyond ninety (90) days if evidence indicates a continued need.

The Program Director stated the facility would make housing changes, transfers, and removal of alleged abusers, and provide emotional support services. The PREA Coordinator stated things she looks for to detect possible retaliation include changes in behavior and youth isolating themselves. She

monitors housing changes and periodic status checks. She stated she would monitor the conduct and treatment of residents and staff who report the sexual abuse of a resident or were reported to have suffered sexual abuse for 90 days. If there is concern that potential retaliation might occur, the maximum length of time that you the facility would monitor conduct and treatment would be until a youth is released from the facility.

115.367 (d)

DCS policy states monitoring should include periodic status checks of children/youth.

The PREA Coordinator stated things she looks for to detect possible retaliation include changes in behavior and youth isolating themselves.

115.367 (e)

DCS policy states if any individual involved in a report expresses fear of retaliation, the Agency takes appropriate measures to protect the individual that includes segregated (protective) housing, as applicable, if voluntarily requested by the individual.

The COO stated the facility would protect residents and staff from retaliation for sexual abuse or sexual harassment allegations through housing changes or transfers and removal of alleged abusers. The Program Director stated the facility would make housing changes, transfers, and removal of alleged abusers, and provide emotional support services. The Program Director stated measures she would take when she suspects retaliation investigation, talking with victims, and talking with retaliating staff or youth.

115.367 (f)

MRC's responsibility to monitor retaliation will terminate if the allegation is unfounded.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding agency protection against retaliation. No corrective action is required.

Standard 115.368: Post-allegation protective custody

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.368 (a)

- Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. MRC Policy: Restraint, Seclusion and Physical Holding
3. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. MRC YD Pre-Audit Questionnaire responses

Interview:

1. Interview with the Facility Director

Site Review Observations:

Observations during on-site review of physical plant

Findings:

PAQ: The facility has a policy that residents who allege to have suffered sexual abuse may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged.

The facility policy requires that residents who are placed in isolation because they allege to have suffered sexual abuse have access to legally required educational programming, special education services, and daily large-muscle exercise.

In the past 12 months:

1. The number of residents who allege to have suffered sexual abuse who were placed in isolation: Zero (0)

If a resident who alleges to have suffered sexual abuse is held in isolation, the facility affords each such resident a review every 30 days to determine whether there is a continuing need for separation from the general population.

The Program Director confirmed MRC does not use isolation.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding post-allegation protective custody. No corrective action is required.

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.371 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☐ Yes ☐ No ☒ NA
- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☐ Yes ☐ No ☒ NA

115.371 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334? ☒ Yes ☐ No

115.371 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No
- Do investigators interview alleged victims, suspected perpetrators, and witnesses? ☒ Yes ☐ No
- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.371 (d)

- Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation? ☒ Yes ☐ No

115.371 (e)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? ☒ Yes ☐ No

115.371 (f)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?
☒ Yes ☐ No
- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

115.371 (g)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No
- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

115.371 (h)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? ☒ Yes ☐ No

115.371 (i)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?
☒ Yes ☐ No

115.371 (j)

- Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention?
☒ Yes ☐ No

115.371 (k)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation?
☒ Yes ☐ No

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

- When an outside agency investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 14.3: Screening, Response Priority and Assignment of Child Protective Services Cases
3. DCS Policy 14.7: Special Child Protective Services Investigations
4. DCS Policy 14.25: Special Child Protective Services Investigations
5. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
6. MRC YD Pre-Audit Questionnaire responses

Interviews:

1. Interview with the Facility Director
2. Interview with the PREA Coordinator
3. Interview with the PREA Compliance Manager
4. Interview with Investigative Staff

Site Review Observations:

1. Observations during on-site review of physical plant

Findings (By Provision):

115.371 (a)

PAQ: The agency/facility does not have a policy related to criminal and administrative agency investigations.

DCS is responsible for allegations of sexual abuse or sexual harassment. The DCS investigator stated once a case is received, it takes less than 24 hours to initiate an investigation following an allegation of sexual abuse or sexual harassment. The investigator confirmed she handles anonymous or third-party reports of sexual abuse and sexual harassment in the same manner as all investigations. She begins by interviewing the individual who reported the allegation. The auditor reviewed the reports for allegations of sexual abuse and sexual harassment and observed they were received in a timely manner.

115.371 (b)

DCS investigators receive specialized training in sexual abuse investigations involving juveniles. The DCS investigator confirmed she received training specific to conducting sexual abuse and sexual harassment investigations in confinement settings through classroom and computer-based training.

115.371 (c)

The DCS Investigator gathers all evidence, reviews video surveillance footage if available, and interviews alleged victims, suspected perpetrators, and witnesses. The investigation will include reviewing any prior complaints and reports of sexual abuse involving the suspected perpetrator. The investigator will not terminate the investigation solely because the victim recants the allegation.

The DCS investigator confirmed the first steps in initiating an investigation is contacting the facility where an allegation of sexual abuse or sexual harassment has been made and requesting all available information. This occurs within 24 hours. She then travels to the facility to review any video footage that may be available, and conducts interviews with the alleged victim, alleged perpetrator, and all witnesses. Direct and circumstantial evidence she would be responsible for gathering in an investigation of an incident of sexual abuse would include video footage, interviews, statements, third-party information, etc.

115.371 (d)

PAQ: The agency does not terminate an investigation solely because the source of the allegation recants the allegation.

The DCS investigator confirmed an investigation does not terminate if the source of the allegation recants the allegation.

115.371 (e)

The DCS investigator confirmed when she discovers evidence that a prosecutable crime may have taken place, she consults with prosecutors before conducting compelled interviews.

115.371 (f)

The DCS investigator confirmed she judges the credibility of an alleged victim, suspect, or witness based on evidence. She stated under no circumstance, does she require a resident who alleges sexual abuse to submit to a polygraph examination or truth telling device as a condition for proceeding with an investigation

115.371 (g)

The DCS investigator confirmed the efforts she makes during an administrative investigation to determine whether staff actions or failures to act contributed to the sexual abuse include investigating the allegation and coordinating with the DCS PREA Coordinator. She confirmed she documents

administrative investigations in written reports. The reports include incident reports, interviews, and all available evidence.

115.371 (h)

The DCS investigator confirmed criminal investigations are documented. There were no criminal investigations during the audit period. The investigations are documented in the appropriate TFACTS incident reporting section.

115.371 (i)

PAQ: Substantiated allegations of conduct that appear to be criminal are referred for prosecution. The number of sustained allegations of conduct that appear to be criminal that were referred for prosecution since the last PREA audit: Zero (0)

The DCS investigator confirmed cases are referred for prosecution only when there are substantiated allegations of conduct that appears to be criminal.

115.371 (j)

PAQ: The agency retains all written reports pertaining to the administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

DCS policy states Agencies maintain sexual abuse data collected pursuant to PREA Standards § 115.387 for at least ten (10) years after the date of its initial collection unless Federal, State, or local law requires otherwise. Refer to CPS Records Disposition Authority (RDA) 2993 regarding closed CPS Case Files that includes documentation of administrative investigations and activities.

115.371 (k)

The DCS investigator confirmed an investigation continues when a staff member alleged to have committed sexual abuse or sexual harassment terminates employment prior to a completed investigation into his/her conduct.

115.371 (l)

Any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements.

115.371 (m)

MRC policy states Memphis Recovery Centers and its employees shall cooperate with outside investigators, and the Director shall endeavor to remain informed about the progress of the investigation. Documentation of each attempt to remain informed shall be kept in the resident's file with the Sexual Abuse Incident Review form and associated documents.

The Program Director, PREA Coordinator, and PREA Compliance Manager stated if an outside agency investigates allegations of sexual abuse, the facility remains informed of the progress of a sexual abuse investigation through the Child Protective Services (CPS) referral tracking system.

The DCS investigator confirmed when an outside agency investigates an incident of sexual abuse in this facility, she would support the investigative process and communicate with the outside agency to remain informed of the progress.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding criminal and administrative agency investigations. No corrective action is required.

Standard 115.372: Evidentiary standard for administrative investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.372 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 14.7: Child Protective Services Investigation Track
3. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. MRC YD Pre-Audit Questionnaire responses

Interview:

1. Interview with DCS Investigative Staff

Site Review Observations:

Observations during on-site review of physical plant

Findings:

PAQ: The agency imposes a standard of a preponderance of the evidence or a lower standard of proof when determining whether allegations of sexual abuse or sexual harassment are substantiated.

DCS policy states a report of child abuse by the alleged perpetrator may be classified as substantiated if there is a preponderance of evidence, in light of the entire record, which substantiated the individual committed physical, severe or child sexual abuse, as defined in Tennessee Code Annotated 37-1-102 or 37-1-602.

The DCS investigator confirmed she refers to the preponderance of the evidence to substantiate allegations of sexual abuse or sexual harassment.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding evidentiary standard for administrative investigations. No corrective action is required.

Standard 115.373: Reporting to residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.373 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? ☒ Yes ☐ No

115.373 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in the agency's facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

115.373 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? ☒ Yes ☐ No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the

resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.373 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No
- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.373 (e)

- Does the agency document all such notifications or attempted notifications? ☒ Yes ☐ No

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. MRC Policy: Input from Persons Served
3. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. Juvenile Notification of Investigative Outcome
5. MRC YD Pre-Audit Questionnaire responses

Interviews:

1. Interview with the Program Director
2. Interview with DCS Investigator
3. Interview with Residents who Reported a Sexual Abuse – N/A

Site Review Observations:

Observations during on-site review of physical plant

Findings (by provision):**115.373 (a)**

PAQ: The agency has a policy requiring that any resident who makes an allegation that he or he suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency.

In the past 12 months:

1. The number of criminal and/or administrative investigations of alleged resident sexual abuse that were completed by the agency/facility: Zero (0)
2. Of the investigations that were completed of alleged sexual abuse, the number of residents who were notified, verbally or in writing, of the results of the investigation: N/A

The Juvenile Notification of Investigative Outcome Form informs any resident who makes an allegation that he or he suffered sexual abuse in an agency facility, in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency.

The Program Director confirmed the facility would notify a resident who makes an allegation of sexual abuse, that the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation.

The DCS Investigator confirmed she is aware that when a resident makes an allegation of sexual abuse, the resident must be informed as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation.

115.373 (b)

PAQ: If an outside entity conducts such investigations, the agency requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation.

In the past 12 months:

1. The number of investigations of alleged resident sexual abuse in the facility that were completed by an outside agency: Zero (0)

2. Of the outside agency investigations of alleged sexual abuse that were completed, the number of residents alleging sexual abuse in the facility who were notified verbally or in writing of the results of the investigation: N/A

115.373 (c)

PAQ: Following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency/facility subsequently informs the resident (unless the agency/facility has determined that the allegation is unfounded) whenever:

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

There has not been a substantiated or unsubstantiated complaint (i.e., not unfounded) of sexual abuse committed by a staff member against a resident in the past 12 months.

Following a resident's allegation that a staff member has committed sexual abuse against the resident, The Juvenile Notification of Investigative Outcome Form informs is used to inform the resident (unless DCS has determined that the allegation is unfounded) whenever:

1. The staff member is no longer posted within the resident's unit (during the investigation, the staff member shall not be in any area with the resident without being directly supervised);
2. The staff member is no longer employed at the facility;
3. The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or
4. The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

115.373 (d)

PAQ: Following a resident's allegation that he or she has been sexually abused by another resident in an agency facility, the agency subsequently informs the alleged victim whenever:

1. The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or
2. The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

Following a resident's allegation that he has been sexually abused by another resident, The Juvenile Notification of Investigative Outcome Form informs is used to subsequently inform the alleged victim whenever:

1. The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or
2. The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

115.373 (e)

PAQ: The agency has a policy that all notifications to residents described under this standard are documented.

In the past 12 months:

1. The number of notifications to residents that were made pursuant to this standard: Zero (0)
2. The number of those notifications that were documented: N/A

All notifications to residents described under this standard are documented with the Juvenile Notification of Investigative Outcome Form.

115.373 (f)

An agency's obligation to report under this standard shall terminate if the resident is released from the agency's custody.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding reporting to residents. No corrective action is required.

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.376 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No

115.376 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☒ Yes ☐ No

115.376 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? ☒ Yes ☐ No

115.376 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No
- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. MRC Ethics Violation Investigation Procedure
4. MRC YD Pre-Audit Questionnaire responses

Site Review Observations:

Observations during on-site review of physical plant

Findings (by provision):

115.376 (a)

PAQ: Staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

MRC policy states actual violations of the MRC Code of Ethics shall result in disciplinary action appropriate to the violation up to and including dismissal.

115.376 (b)

In the past 12 months:

1. The number of staff from the facility that have violated agency sexual abuse or sexual harassment policies: Zero (0)
2. The number of those staff from the facility that have been terminated (or resigned prior to termination) for violating agency sexual abuse or sexual harassment policies: Zero (0)

MRC policy states actual violations of the MRC Code of Ethics shall result in disciplinary action appropriate to the violation up to and including dismissal.

115.376 (c)

PAQ: Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories.

In the past 12 months, the number of staff from the facility that have been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies: Zero (0)

115.376 (d)

PAQ: All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. In the past 12 months, the number of staff from the facility that have been reported to law enforcement or licensing boards following their termination (or resignation prior to termination) for violating agency sexual abuse or sexual harassment policies: Zero (0)

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding disciplinary sanctions for staff. No corrective action is required.

Policy Suggestions

115.376 (c) and (d) Policy is not expressly inclusive of these standard provisions.

Standard 115.377: Corrective action for contractors and volunteers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.377 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

115.377 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. MRC Policy: Program Volunteers
3. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
4. MRC YD Pre-Audit Questionnaire responses

Interview:

1. Interview with the Facility Director

Site Review Observations:

Observations during on-site review of physical plant

Findings (by provision):

115.377 (a)

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

In the past 12 months, no contractors or volunteers have been reported to law enforcement agencies and relevant licensing bodies for engaging in sexual abuse of residents.

MRC does not use the services of volunteers or contractors.

115.377 (b)

PAQ: The facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

MRC does not use the services of volunteers or contractors.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding corrective action for contractors and volunteers. No corrective action is required.

Standard 115.378: Interventions and disciplinary sanctions for residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.378 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may

residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process?

☒ Yes ☐ No

115.378 (b)

- Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise? ☒ Yes ☐ No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services? ☒ Yes ☐ No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician? ☒ Yes ☐ No
- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.378 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? ☒ Yes ☐ No

115.378 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions? ☒ Yes ☐ No
- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education? ☒ Yes ☐ No

115.378 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

115.378 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an

incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No

115.378 (g)

- If the agency prohibits all sexual activity between residents, does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. MRC YD Pre-Audit Questionnaire responses

Interviews:

1. Interview with the Facility Director
2. Interviews with Medical and Mental Health Practitioners

Site Review Observations:

Observations during on-site review of physical plant

Findings (by provision):

115.378 (a)

PAQ: Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse. Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following a criminal finding of guilt for resident-on-resident sexual abuse.

In the past 12 months:

1. The number of administrative findings of resident-on-resident sexual abuse that have occurred at the facility: Zero (0)
2. The number of criminal findings of guilt for resident-on-resident sexual abuse that have occurred at the facility: Zero (0)

115.378 (b)

PAQ: In the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, the facility policy requires that residents in isolation have daily access to large muscle exercise, legally required educational programming, and special education services. In the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, residents in isolation receive daily visits from a medical or mental health care clinician. In the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, residents in isolation have access to other programs and work opportunities to the extent possible. In the past 12 months:

1. The number of residents placed in isolation as a disciplinary sanction for resident-on resident sexual abuse: Zero (0)
2. The number of residents placed in isolation as a disciplinary sanction for resident-on resident sexual abuse, who were denied daily access to large muscle exercise, and/or legally required educational programming, or special education services: N/A
3. The number of residents placed in isolation as a disciplinary sanction for resident-on resident sexual abuse, who were denied access to other programs and work opportunities: N/A

MRC does not use isolation as a disciplinary sanction.

The Program Director stated disciplinary sanctions residents are subject to following an administrative or criminal finding the resident engaged in resident-on-resident sexual abuse would include loss of privileges. The sanctions would be proportionate to the nature and circumstances of the abuses committed, the residents' disciplinary histories, and the sanctions imposed for similar offenses by other residents with similar histories. Isolation is not used as a disciplinary sanction.

115.378 (c)

The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his behavior when determining what type of sanction, if any, should be imposed.

The Program Director stated mental disability or mental illness is considered when determining sanctions.

115.378 (d)

PAQ: The facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. If the facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse, the facility considers whether to require the offending resident to participate in such interventions as a condition of access to any rewards-based behavior management system or other behavior based incentives. Access to general programming or education is not conditional on participation in such interventions.

The psychologist stated if the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to offer the offending resident participation in such interventions.

115.378 (e)

PAQ: The agency disciplines residents for sexual contact with staff only upon finding that the staff member did not consent to such contact.

115.378 (f)

PAQ: The agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.

DCS policy states report made in good faith upon reasonable belief of the alleged incident does not constitute a false report and may not be used as grounds for disciplinary action.

115.378 (g)

PAQ: The agency prohibits all sexual activity between residents. The agency deems such activity to constitute sexual abuse only if it determines that the activity is coerced.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding disciplinary sanctions for residents. No corrective action is required.

Policy Suggestions

115.376 (a), (c), (d), (e), and (g) Policy is not expressly inclusive of these standard provisions.

MEDICAL AND MENTAL CARE

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.381 (a)

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (b)

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (c)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law? ☒ Yes ☐ No

115.381 (d)

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. MRC YD Pre-Audit Questionnaire responses
4. Assessment, Checklist and Protocol for Behavior and Risk for Victimization

Interviews:

1. Interview with Staff Responsible for Risk Screening
2. Interviews with Residents who Disclosed Sexual Victimization at Risk Screening

Site Review Observations:

Observations during on-site review of physical plant

Findings (by provision):

115.381 (a)

PAQ: All residents at this facility who have disclosed any prior sexual victimization during a screening pursuant to §115.341 are offered a follow-up meeting with a medical or mental health practitioner. The follow-up meeting was offered within 14 days of the intake screening. Medical and mental health practitioners maintain secondary materials (e.g., form, log) documenting compliance with the above required services. In the past 12 months, the percent of residents who disclosed prior victimization during screening who were offered a follow up meeting with a medical or mental health practitioner: 100%

DCS policy requires if further screenings or assessments indicate a child/youth has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, designated staff ensures that the child/youth is offered a follow-up meeting with a medical or mental health practitioner within fourteen (14) days of the intake screening.

The Staff Responsible for Risk Screening confirmed that if screening indicates that a resident has experienced prior sexual victimization, whether in an institutional setting or in the community, a follow-up meeting is offered. She confirmed the meeting would occur within fourteen (14) days.

The auditor interviewed three (3) residents who disclosed prior sexual victimization during risk screening. One (1) of the residents declined a follow-up meeting and two (2) residents stated they met with their primary therapist within fourteen (14) days.

115.381 (b)

PAQ: All residents who have previously perpetrated sexual abuse, as indicated during the screening pursuant to § 115.341, are offered a follow-up meeting with a mental health practitioner. The follow-up

meeting was offered within 14 days of the intake screening. Mental health staff maintain secondary materials (e.g., form, log) documenting compliance with the above required services. In the past 12 months, the percent of residents who previously perpetrated sexual abuse, as indicated during screening, who were offered a follow up meeting with a mental health practitioner: 100%

DCS policy states if the screening indicates that a child/youth has previously perpetrated sexual abuse/assault/misconduct/harassment, whether it occurred in an institutional setting or in the community, designated staff ensure that the child/youth is offered a follow-up meeting with a mental health practitioner within fourteen (14) days of the intake screening.

The Staff Responsible for Risk Screening confirmed that if screening indicates that a resident previously perpetrated sexual abuse, whether in an institutional setting or in the community, a follow-up meeting is offered with a psychologist. She confirmed the meeting would occur within fourteen (14) days.

115.381 (c)

PAQ: Information related to sexual victimization or abusiveness that occurred in an institutional setting is strictly limited to medical and mental health practitioners.

115.381 (d)

PAQ: Medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting unless the resident is under the age of 18.

Medical and mental health practitioners confirmed informed consent from residents is required for residents 18 and older before reporting about prior sexual victimization that did not occur in an institutional setting.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding medical and mental health screenings, history of sexual abuse. No corrective action is required.

Standard 115.382: Access to emergency medical and mental health services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.382 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment? ☒ Yes ☐ No

115.382 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362? ☒ Yes ☐ No
- Do staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.382 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☒ Yes ☐ No

115.382 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. DCS Protocol: First Responder Guidelines for Sexual Assault
4. MRC YD Pre-Audit Questionnaire responses

Interviews:

1. Interviews with Medical and Mental Health Practitioners
2. Interviews with Residents who Reported a Sexual Abuse – N/A

3. Interviews with Security Staff and Non-Security Staff First Responders

Site Review Observations:

Observations during on-site review of physical plant

Findings (by provision):

115.382 (a)

PAQ: Resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. Medical and mental health practitioners maintain secondary materials (e.g., form, log) documenting the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning contraception and sexually transmitted infection prophylaxis.

DCS policy for those sexual abuse incidents alleged to have occurred within seventy-two (72) hours, the Agency nursing personnel/designee offers to take the child/youth to the local hospital emergency room for examination, collection and preservation of evidence, and treatment.

Children/youth who are the victim of sexual abuse are provided prompt and appropriate medical treatment and counseling, to include is but not limited to: Agency staff, as applicable, provides emotional support to child/youth with the forensic medical exam process and investigation interviews.

The Director of the Shelby County Rape Crisis Center said services for sexual abuse that has occurred within 92 hours would be provided at the center. If there are serious injuries the services would be provided at Le Bonheur Children's Hospital ER. If the sexual abuse occurred over 92 hours services would be provided at the Memphis Child Advocacy Center.

Medical and mental health care staff ensure resident victims of sexual abuse receive immediate and unimpeded access to emergency medical treatment and crisis intervention services. The psychologist and the nurse stated the nature and scope of these services would be determined according to their professional judgment medical procedures.

115.382 (b)

Staff were knowledgeable of their first responder duties. If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim and shall immediately notify the appropriate medical and mental health practitioners.

115.382 (c)

PAQ: Resident victims of sexual abuse while incarcerated are offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Medical and mental health practitioners maintain secondary materials documenting the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.

The nurse confirmed resident victims of sexual abuse while incarcerated are offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.

115.382 (d)

PAQ: Treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

DCS policy states treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding access to emergency medical and mental health services. No corrective action is required.

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

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.383 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

115.383 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☒ Yes ☐ No

115.383 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

115.383 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☒ Yes ☐ No ☐ NA

115.383 (e)

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if “all-male” facility. *Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☒ Yes ☐ No ☐ NA

115.383 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

115.383 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

115.383 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA

2. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. MRC YD Pre-Audit Questionnaire responses

Interviews:

1. Interviews with Medical and Mental Health Practitioners
2. Interviews with Residents who Reported a Sexual Abuse – N/A

Site Review Observations:

Observations during on-site review of physical plant

Findings (by provision):**115.383 (a)**

PAQ: The facility offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.

DCS policy states children/youth who are the victim of sexual abuse are provided prompt and appropriate medical treatment and counseling.

115.383 (b)

MRC policy states evaluation and treatment of victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.

DCS policy states follow-up services and referrals are provided, as applicable, for continued care following transfer to, or placement in other facilities, or release from custody. A safety action plan that includes a review/adjustment, if necessary, of appropriate housing, bed, program, education, and work assignments to keep child/youth safe and free from sexual abuse may be developed.

The psychologist stated residents who have been victimized would be provided follow-up services, treatment plans would be developed, and referrals for continued care would be arranged after the youth are released. The nurse stated treatment would include follow-up services, following recommendations made by the ER, and providing trauma-based therapy.

115.383 (c)

MRC policy states victims shall receive medical and mental health services consistent with the community level of care.

The nurse and psychologist stated they consider medical and mental health services are consistent with the community level of care.

115.383 (d)

PAQ: Female victims of sexual abusive vaginal penetration while incarcerated are offered pregnancy tests.

DCS policy states female victims, as applicable, are offered pregnancy tests.

115.383 (e)

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

DCS policy states if pregnancy tests are positive, such victims receive timely and comprehensive information about timely access to all lawful pregnancy related medical services.

The nurse confirmed if pregnancy results from sexual abuse while incarcerated, victims receive timely and comprehensive information about, and timely access to, all lawful pregnancy-related medical services the Shelby County Rape Crisis Center. These services would be provided immediately.

115.383 (f)

PAQ: Resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate.

DCS policy states children/youth are offered tests for sexually transmitted infections as medically appropriate.

115.383 (g)

PAQ: Treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

DCS policy states treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

115.383 (h)

PAQ: The facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate by mental health practitioners.

MRC policy children/youth who are the victim of sexual abuse are provided prompt and appropriate medical treatment and counseling, to include is but not limited to an assessment by a mental health professional.

The psychologist confirmed a mental health evaluation of all known resident-on-resident abusers would be conducted and they would be offered treatment if appropriate.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding ongoing medical and mental health care for sexual abuse victims and abusers. No corrective action is required.

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.386 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☒ Yes ☐ No

115.386 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

115.386 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

115.386 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.386 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. MRC YD Pre-Audit Questionnaire responses
4. Sexual Abuse Incident Review Form

Interviews:

1. Interview with the Facility Director
2. Interview with the PREA Compliance Manager
3. Interview with an Incident Review Team Member

Site Review Observations:

Observations during on-site review of physical plant

Findings (by provision):

115.386 (a)

PAQ: The facility conducts a sexual abuse incident review at the conclusion of every sexual abuse criminal or administrative investigation unless the allegation has been determined to be unfounded. In the past 12 months, the number of criminal and/or administrative investigations of alleged sexual abuse completed at the facility, excluding only "unfounded" incidents: Zero (0)

DCS policy states the Agency conducts a sexual abuse incident review within thirty (30) days of the close of every sexual abuse investigation involving a PREA-related incident unless the outcome was unfounded.

The auditor reviewed the Sexual Abuse Incident Review form for verification.

115.386 (b)

PAQ: The facility ordinarily conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation.

In the past 12 months, the number of criminal and/or administrative investigations of alleged sexual abuse completed at the facility that were followed by a sexual abuse incident review within 30 days, excluding only “unfounded” incidents: Zero (0)

DCS policy states the Agency conducts a sexual abuse incident review within thirty (30) days of the close of every sexual abuse investigation involving a PREA-related incident unless the outcome was unfounded.

The auditor reviewed the Sexual Abuse Incident Review form for verification.

115.386 (c)

PAQ: The sexual abuse incident review team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners.

DCS policy states the review team consists of management level staff/designees, as applicable, with input from line supervisors, investigators, and medical and/or mental health practitioners.

The Program Director confirmed the facility has a sexual abuse incident review team.

115.386 (d)

PAQ: The facility prepares a report of its findings from sexual abuse incident reviews, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submits such report to the facility head and PREA compliance manager.

DCS policy states the review team:

1. Considers whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect or respond to sexual abuse;
2. Considers whether the incident or allegation was motivated by:
 - Race;
 - Ethnicity;
 - Gender identity;
 - Lesbian, gay, bisexual, transgender, intersex, or gender non-conforming identification, status, or perceived status; or
 - Gang affiliation or was motivated or otherwise caused by other group dynamics at the Agency.
3. Examines the area in the YDC/Agency where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;
4. Assesses the adequacy of staffing levels in that area during different shifts;
5. Assesses whether monitoring technology should be deployed or augmented to supplement supervision by staff; and
6. Prepares a report of its findings including, but not limited to determinations made pursuant to paragraphs 2. B) of this Section, and any recommendations for improvement and submit the report facility head and PREA Compliance Manager.

The Program Director confirmed the sexual abuse incident review team uses the information from the sexual abuse incident review to identify problems and make corrective actions. The team considers whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; and/or other group dynamics at the facility; the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; assess the adequacy of staffing levels in that area during different shifts; and assess whether monitoring technology should be deployed or augmented to supplement supervision by staff.

The PREA Coordinator confirmed if the facility conducts a sexual abuse incident review, the facility prepares a report of its findings from the review, including any determinations any recommendations for improvement. The PREA Coordinator is a member of the sexual abuse incident review team.

115.386 (e)

PAQ: The facility implements the recommendations for improvement or documents its reasons for not doing so.

DCS policy states the Agency implements the recommendations for improvement, or documents reasons for not doing so, e.g., inadequate funding or staffing issues.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding sexual abuse incident reviews. No corrective action is required.

Standard 115.387: Data collection

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.387 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

115.387 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually?
☒ Yes ☐ No

115.387 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

115.387 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?
☒ Yes ☐ No

115.387 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☐ Yes ☐ No ☒ NA

115.387 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)
☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. MRC YD Pre-Audit Questionnaire responses
4. Survey of Sexual Victimization Substantiated Incident Form (Juvenile)

Documents (Corrective Action):

1. Annual Reports

Site Review Observations:

Observations during on-site review of physical plant

Findings (by provision):

115.387 (a)

PAQ: The agency collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The standardized instrument includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

DCS policy states DCS/Agencies collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions as instructed by the DCS Statewide PREA Coordinator. The incident-based data collected includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Victimization conducted by the Department of Justice.

115.387 (b)

PAQ: The agency aggregates the incident-based sexual abuse data at least annually.

The auditor reviewed the aggregated data from 2014 to 2020.

115.387 (c)

PAQ: The incident-based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

DCS policy states the incident-based data collected includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Victimization conducted by the Department of Justice.

The auditor reviewed the Survey of Sexual Victimization Substantiated Incident Form (Juvenile) for verification.

115.387 (d)

PAQ: The agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

DCS policy states Agencies maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

115.387 (e) N/A

The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents.

MRC does not contract with other facilities for the confinement of its residents.

115.387 (f)

Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

DCS policy states upon request, Agencies provide all such data from the previous calendar year to the Department of Justice no later than June 30th.

The Department of Justice did not request MRC provide all such data from the previous calendar year.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding data collection. No corrective action is required.

Standard 115.388: Data review for corrective action

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.388 (a)

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No
- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No
- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☐ Yes ☒ No

115.388 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☐ Yes ☒ No

115.388 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☐ Yes ☒ No

115.388 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. MRC YD Pre-Audit Questionnaire responses

Documents (Corrective Action):

1. Annual Reports

Interviews:

1. Interview with the Agency Head Designee (COO)
2. Interview with the PREA Coordinator
3. Interview with the PREA Compliance Manager

Site Review Observations:

Observations during on-site review of physical plant

Findings (by provision):

115.388 (a)

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

1. Identifying problem areas;
2. Taking corrective action on an ongoing basis; and
3. Preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the agency as a whole.

DCS/ policy states Agencies review data collected and aggregated pursuant to PREA Standards § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including:

1. Identifying problem areas;
2. Taking corrective action on an ongoing basis; and

3. Preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the Agency as a whole.

The COO stated the facility uses incident-based sexual abuse data to assess and improve sexual abuse prevention, detection, response policies, practices, and training to identify problem areas and take corrective action as needed. The PREA Coordinator confirmed the agency reviews data collected and aggregated in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training.

The agency has not completed annual reports. This standard provision will be addressed through corrective action.

115.388 (b)

PAQ: The annual report includes a comparison of the current year's data and corrective actions with those from prior years. The annual report provides an assessment of the agency's progress in addressing sexual abuse.

DCS policy states the annual report includes a comparison of the current year's data and corrective actions with those from prior years and provides an assessment of the agency's progress in addressing sexual abuse.

The agency has not completed annual reports. This standard provision will be addressed through corrective action.

The auditor reviewed the annual reports for verification.

115.388 (c)

PAQ: The agency makes its annual report readily available to the public at least annually through its website. The annual reports are approved by the agency head.

DCS policy states Agencies make all aggregated sexual abuse data from facilities under its direct control and contract agency facilities with which it contracts, readily available to the public at least annually through its website or through other means, as applicable.

The agency has not completed annual reports. This standard provision will be addressed through corrective action.

The COO confirmed the agency head will approve annual reports upon completion.

The auditor observed the annual reports were published on the agency's website and approved by the agency head.

115.388 (d)

PAQ: When the agency redacts material from an annual report for publication the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility. The agency indicates the nature of material redacted.

DCS policy states before making aggregated sexual abuse data publicly available, Agencies remove all personal identifiers.

The PREA Coordinator stated names and identifying information will be redacted from the annual report and the agency will indicate the nature of material redacted.

The auditor observed no personal identifiers were included in the annual report.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding data review for corrective action. Corrective action was required.

115.388 (a) – (d)

PREA compliant Annual Reports were required. The agency added sexual abuse and sexual allegations data for 2014-2020 on the website. The auditor reviewed the website for verification. Corrective action is complete.

Standard 115.389: Data storage, publication, and destruction

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.389 (a)

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained?
☒ Yes ☐ No

115.389 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.389 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☒ No

115.389 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

- ☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☒ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

Documents:

1. MRC Policy: PREA
2. DCS Policy 18.8: Zero-Tolerance Standards and Guidelines for Sexual Abuse, Sexual Harassment, Assault or Rape Incidents and PREA
3. MRC YD Pre-Audit Questionnaire responses

Documents (Corrective Action):

1. Annual Reports

Interview:

1. Interview with the PREA Coordinator

Site Review Observations:

Observations during on-site review of physical plant

Findings (by provision):

115.389 (a)

PAQ: The agency ensures that incident-based and aggregate data are securely retained.

MRC policy states Memphis Recovery Centers will ensure that data collected pursuant to PREA Standard § 115.387 is securely retained.

DCS policy states Agencies ensure that data collected pursuant to PREA Standard §115.387 are securely retained.

The PREA Coordinator confirmed the agency ensures the data collected pursuant to §115.387 are securely retained.

115.389 (b)

PAQ: Agency policy requires that aggregated sexual abuse data from facilities under its direct control and private facilities with which it contracts be made readily available to the public, at least annually, through its website.

DCS policy states Agencies make all aggregated sexual abuse data from facilities under its direct control and contract agency facilities with which it contracts, readily available to the public at least annually through its website or through other means, as applicable.

The auditor observed the annual reports were not published on the agency's website. This standard provision will be addressed through corrective action.

115.389 (c)

PAQ: Before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers.

DCS policy states before making aggregated sexual abuse data publicly available, Agencies remove all personal identifiers.

This standard provision was addressed through corrective action.

115.389 (d)

PAQ: The agency maintains sexual abuse data collected pursuant to §115.387 for at least 10 years after the date of initial collection, unless Federal, State, or local law requires otherwise.

DCS policy states Agencies maintain sexual abuse data collected pursuant to PREA Standards § 115.387 for at least ten (10) years after the date of its initial collection unless Federal, State, or local law requires otherwise.

The auditor reviewed sexual abuse data from 2014 through 2020.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding data storage, publication, and destruction. Corrective action was required.

115.389 (b) and (c)

PREA compliant Annual Reports were required. The agency added sexual abuse and sexual allegations data for 2014-2020 on the website. The auditor reviewed the website for verification. Corrective action is complete.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard.*) ☐ Yes ☒ No
- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☒ Yes ☐ No ☐ NA
- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with residents? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

1. MRC YD Pre-Audit Questionnaire responses
2. Policy Review
3. Research
4. Documentation Review
5. Interviews
6. Observations during onsite review of facility

Conclusion:

During the three-year period starting on August 20, 2013, and the current audit cycle, Memphis Recovery Centers Youth Development was audited in 2014, 2017, and 2020.

The auditor was given access to, and the ability to observe, all areas of the audited facility. The auditor was permitted to conduct private interviews with residents at the facility. The auditor sent an audit notice to the facility more than six weeks prior to the on-site audit. The facility confirmed the audit notice was posted by emailing pictures of the posted audit notices. The audit notice contained contact information for the auditor. The residents were permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel. No confidential information or correspondence was received.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding frequency and scope of audits. No corrective action is required.

Standard 115.403: Audit contents and findings

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all 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 the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making the compliance determination:

1. MRC YD Pre-Audit Questionnaire responses
2. Policy Review
3. Documentation Review
4. Interviews
5. Observations during onsite review of facility

Conclusion:

The agency has published on its agency website all Final Audit Reports. This standard was addressed through corrective action.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding audit contents and findings. Corrective action was required.

All previous audit reports were published on the MRC website. The auditor reviewed the website for verification. Corrective action is complete.

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 resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.¹ Auditors are not permitted to submit audit reports that have been scanned.² See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Robert Burns Latham

April 27, 2021

Auditor Signature

Date

¹ See additional instructions here: <https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110>.

² See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.