Prison Rape Elimination Act (PREA) Audit Report

Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Report November 5, 2018

Auditor Information

Name: Dwight L. Fondren	**Email:** fondu714@hotmail.com
Company Name: Correctional Management and Communication Group LLC.	
Mailing Address: 6208 NW 78th Street	**City, State, Zip:** Kansas City, MO 64151
Telephone: 816-699-0244	**Date of Facility Visit: October 16, 2018**

Agency Information

Name of Agency Office of State Courts Admission		**Governing Authority or Parent Agency** *(If Applicable)* Click or tap here to enter text.	
Physical Address: 1400 South Boundary Street, Kirksville, MO 63501		**City, State, Zip:** Click or tap here to enter text.	
Mailing Address: Click or tap here to enter text.		**City, State, Zip:** Click or tap here to enter text.	
Telephone: 660-665-4224		**Is Agency accredited by any organization?** ☐ Yes ☐ No	
The Agency Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☒ State	☐ Federal

Agency mission: To provide a safe, caring, structured and supportive environment. The staff and facility will promote respect and motivate the juvenile to learn and act responsibly, both as individuals and as part of the community. To promote an atmosphere of cooperation, with respect for individual differences and community values. Recognizing that each resident is an individual and that all Residents are unique. Staff will ensure that all residents are provided with every opportunity to succeed.

Agency Website with PREA Information: www.juvenilecircuit2.org

Agency Chief Executive Officer

Name: Phyllis Becker	**Title:** Director of Division of Youth Services
Email: Phyllis.Becker@dss.mo.gov	**Telephone:** 573-751-3324

Agency-Wide PREA Coordinator

Name: Amy Kyriazis	**Title:** Senior Program Administrator
Email: Amy.Kyriazis@dss.mo.gov	**Telephone:** 573-751-3324
PREA Coordinator Reports to: Phyllis Becker	**Number of Compliance Managers who report to the PREA Coordinator** 1

Facility Information

Name of Facility: Bruce Normile Juvenile Justice Center				
Physical Address: 1400 S. Boundary Street, Kirksville, MO 63501				
Mailing Address (if different than above): Click or tap here to enter text.				
Telephone Number: 660-665-4224				
The Facility Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit	
☐ Municipal	☐ County	☒ State	☐ Federal	
Facility Type:	☒ Detention	☐ Correction	☐ Intake	☐ Other
Facility Mission: The mission of the Second Judicial Circuit, Juvenile Division is to safeguard our children and communities by employing early-intervention efforts for at-risk children, ensuring empowerment for the victims and families of youthful offenders, securing effective strength-based educational and rehabilitation opportunities for offenders and families, and utilizing efficient multi-agency collaboration to address all of the family's needs.				
Facility Website with PREA Information: www.juvenilecircuit2.org				
Is this facility accredited by any other organization? ☐ Yes ☒ No				

Facility Administrator/Superintendent

Name: Misty Goings	**Title:** Detention Superintendent
Email: Misty.Goings@courts.mo.gov	**Telephone:** 660-665-4224

Facility PREA Compliance Manager

Name: Misty Goings	**Title:** Detention Superintendent
Email: Misty.Goings@courts.mo.gov	**Telephone:** 660-665-4224

Facility Health Service Administrator

Name: Gary Burning	**Title:** ATSU Resident Doctors
Email: GBrunning@ATSU.EDU	**Telephone:** 660-626-2698

Facility Characteristics

Designated Facility Capacity: 14	**Current Population of Facility:** 7	
Number of residents admitted to facility during the past 12 months		105
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:		47
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:		79
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:		0
Age Range of Population:	12-17	
Average length of stay or time under supervision:		20 days
Facility Security Level:		Maximum
Resident Custody Levels:		Maximum
Number of staff currently employed by the facility who may have contact with residents:		21
Number of staff hired by the facility during the past 12 months who may have contact with residents:		7
Number of contracts in the past 12 months for services with contractors who may have contact with residents:		0
Physical Plant		
Number of Buildings: 1	**Number of Single Cell Housing Units:** 14	
Number of Multiple Occupancy Cell Housing Units:	0	
Number of Open Bay/Dorm Housing Units:	0	
Number of Segregation Cells (Administrative and Disciplinary:	2	
Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.): There are twenty eight total cameras located on facility grounds. The control room monitors the cameras on a twenty-four hour basis		
Medical		
Type of Medical Facility:	Forensic Sexual Assault Medical Exams	
Forensic sexual assault medical exams are conducted at:	Northeast Regional Hospital	
Other		
Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:		2
Number of investigators the agency currently employs to investigate allegations of sexual abuse:		0

Audit Findings

Audit Narrative

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.

The Bruce Normile Juvenile Justice Center (BNJJC) is a hardware secure, 14 bed facility, housing both male and female youth (ages 12-17) under the direction of the Office of State Courts Administration. The facility is located in Kirksville, Missouri, and employs 21 full-time staff. The youth being held in the Bruce Normile Juvenile Justice Center have been sentenced in the court system and are awaiting placement or have a pending trial. The youth attend school daily directed the Kirksville Public school system.

Audit Methodology

Pre-Onsite Audit Phase

The BNJJC Agency PREA Coordinator (APC) 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 prior to the site visit. The PREA Auditor was in communication with the APC and Facility Administrator directly. The Facility Administrator/Superintendent serves as the facility's PREA Compliance Manager (PCM). The APC and PCM were very receptive to the audit process and were well informed of the role of the Auditor and the expectations during each stage of the PREA audit.

The notification of the on-site audit at Bruce Normile Juvenile Justice Center (BNJJC) was posted on September 4, 2018, six weeks prior to the date of the onsite audit. The posting of the notices was verified by photographs received electronically from the APC. The photographs provided with the Pre-Audit information indicated notices were posted strategically throughout the facility, accessible to residents, staff, visitors, contractors, and volunteers. The auditor noticed that the notifications were placed in the lobby, hallways, living units, and common areas. The posted audit notices contained the Auditor's contact information and included information regarding confidentiality. The notice was posted in English and Spanish and at eye levels easy for a person to see either standing or sitting. All residents in the facility during the time of the site visit spoke and read English. No correspondence was received during any phase of the audit.

Approximately 6 to 8 weeks prior to the auditor's onsite visit to the facility, the auditor worked with the APC in developing and completing the Pre-Audit Questionnaire (PAQ). This document identified the minimum information and supporting documents that the facility should submit to the auditor before the onsite audit begins. The BNJJC PAQ was received on September 18, 2018, and included policies, procedures and supporting documentation which was within an adequate timeframe for review. The completed PREA Pre-Audit Questionnaire, policies and procedures, and supporting documentation were uploaded to a flash drive and mailed to the Auditor. This flash drive was received by the Auditor well over a month before the site visit.

An initial assessment was conducted of the information provided and it was determined the information was provided in detail on the flash drive. The documentation on the flash drive was well organized by

each standard, including the identified provisions of each standard. Additional information requested during the site visit was provided or explained by the APC.

The APC had been previously provided a document by the auditor titled, “Information Requested to Determine Staff and Residents to be interviewed during the On-site PREA Audit.” The document was completed and provided the Auditor onsite. The document requested the identification of the staff members who served and performed in specific PREA related specialized roles within the facility, including volunteers and contractors who have contact with residents. The document requested a list of security staff and their shift assignments and a resident population roster. Additionally, the request included information regarding residents who may be in vulnerable categories such as disabled; limited English proficient; intersex, gay, lesbian, bisexual and/or transgender residents; and residents housed in isolation.

The Auditor communicated with the APC and the PCM to confirm schedules and to clarify specialized PREA roles. A current resident roster was also provided to the Auditor. As a result of the information received, the Auditor developed an interview schedule of specialized and random staff and residents, including targeted resident interviews.

The facility provided the lists and information before or during the site visit that assisted with the following determinations and interview selections:

Lists/Information	Comments
Complete Resident Roster	An up-to-date roster was provided prior to the site visit.
Youthful inmates/detainees	Youthful inmates/detainees are not housed in this facility.
Residents with disabilities	**One** was identified.
Residents who are Limited English Proficient	None were identified.
LGBTI Residents	**One** was identified.
Residents who identified as Transgender/Intersex	None were identified
Residents in segregated housing	None were identified in segregated housing.
Residents in Isolation	No residents were in isolation.
Residents with Cognitive disabilities	**Two** residents were identified.
Residents who reported sexual abuse	**One** was Identified.
Residents who reported sexual victimization during risk screening	**One** was identified.
Staff roster for the time of the site visit	The roster was provided during the pre-onsite phase of the audit.
Specialized Staff	Specialized staff was identified and interviewed.
Contractors who have contact with the residents	Contractors were identified on interview document sent to the facility and on flash drive.
Volunteer who has contact with the residents	Volunteers identified on interview document sent to the facility and on flash drive.
All grievances/allegations made in the 12 months preceding the audit	None.
All allegations of sexual abuse and sexual harassment reported for investigation in the 12 months preceding the audit	None.
Hotline calls made during the 12 months preceding the audit	None.
Detailed list of number of sexual abuse and sexual harassment allegations in the 12 months preceding the audit	The facility reported there were no allegations of sexual abuse or sexual harassment in the 12 months preceding the audit.

The Auditor reviewed the lists/documents provided and conferred with the APC and Superintendent in development of the interview schedule to ensure clarity regarding specialized PREA roles among staff.

Internet research of the facility revealed no indication of litigation, U. S. Department of Justice involvement, or federal consent decrees. General and specific information about the facility and the programs and services provided are detailed on the facility's website. An array of information, pictures of the facility and contact information may be accessed from the informative page. The facility's website also contains PREA information including but not limited to the zero-tolerance and coordinated response policies. The PREA audit report for the initial audit in 2016 is located on the website and it also contains the third-party reporting form.

Onsite Audit Phase

The on-site visit was conducted October 16, 2018 by Dwight L. Fondren (Auditor). The Auditor arrived onsite during the early morning hours in order to interview some staff members on the overnight shift and observe early morning operations. BNJJC random staff members working the overnight shift were interviewed immediately upon the Auditors' arrival to the facility to reduce the accrual of overtime hours. Once the interviews were completed, an entrance conference was conducted. In addition to the Auditor, the entrance conference included the facility Superintendent/PCM. During the conference the Auditor discussed the information contained in the PAQ. Formal introductions were made and a review of the audit process, site visit activities and the itinerary. Site review Instructions were covered to include a description of the areas of the facility to be toured; operations and practices to be observed; and questions that should be asked of staff and residents to conduct a thorough site review. Additionally, interview protocols to be used by the Auditor to interview staff and residents as part of the audit were discussed. Required documentation, relevant observations, the interview protocols, and the audit compliance tool were used to establish evidence of standard compliance. At the time of this audit, the facility employed 21 staff. The resident population was 7 males and no females.

Upon completion of the entrance conference, a comprehensive site review of the facility was conducted and led by the PCM. The tour included all areas of the facility. The staff was observed providing direct supervision to the residents. During the pre-audit phase, the Auditor was provided a diagram of the physical plant which provided familiarity with the layout of the facility. The program is housed in one building which includes 14 housing units, gymnasium, conference room, staff offices, a kitchen and storage rooms. Resident files were observed to be maintained securely in locked file cabinets in an office which is kept locked when unoccupied. The file cabinets located in the PCM's office have limited and identified key access.

During the comprehensive site review, the printed notifications of the PREA site visit were observed posted in the areas previously identified in the pictures sent to the Auditor, such as living units, lobby and common areas for residents and staff. The notices contained large enough print to make them accessible and easy to see and read and in English and Spanish. Posted signs were observed regarding general PREA information including emergency and non-emergency numbers for assistance. The posted information included instructions on accessing the 24/7 hotline for reporting allegations and requesting advocacy services.

Questions were answered by staff during informal interviews regarding resident activities and program services as the site review progressed throughout the facility. The site visit also included the outside grounds. During the comprehensive site review, the intake process was described and the daily scheduled activities and staff supervision were discussed by the Superintendent. There were no new admissions during the site visit. Staff readily explained activities as different facility areas were visited.

Residents were observed in their cells preparing for the daily scheduled programming assignments. In addition to security staff members providing direct supervision to residents, another staff member was

monitoring the camera system in the central control area/staff workstation. Telephones were observed in each living unit for reporting allegations of sexual abuse and sexual harassment; the telephones were in working order. The reporting process was discussed during the site review. Directions for accessing the crisis hotline were posted and included the limitations of confidentiality.

Male and Female staff were observed knocking on entrance doors to alert the residents that opposite gender staff were entering the unit. All residents interviewed stated staff members knock or announce their presence when entering the living unit. This practice was experienced and observed during the comprehensive site review. Visibility is enhanced with the strategic use of cameras, mirrors and windows in doors. There are no cameras in bathrooms and reasonable privacy is provided to residents when they use the toilet, change clothes and shower. The shower procedures are printed and posted at the entrance of the bathroom on each unit.

Medical Request Forms, grievance forms, and the locked boxes for each are posted in the common area, accessible to all residents, staff and visitors. All residents have access to writing utensils needed for completing the forms. Signage was posted which indicated where residents were not allowed or only allowed with staff supervision. The doors to closets and storage rooms are kept locked.

A Memorandum of Understanding (MOU) exists with The Rainbow House to receive allegations of sexual abuse and sexual harassment and for the provision of advocacy services upon request. The Program Manager was interviewed by phone and confirmed the advocacy services to be provided in accordance with the MOU. Documentation and interviews with the Nurse and Medical Director confirmed forensic medical examinations will be performed at Northeast Regional Hospital located in Kirksville, MO. The hospital's Sexual Assault Policy provides that a Sexual Assault Nurse Examiner (SANE) will conduct the examinations. According to the Hospital's written Policy, when a SANE is not available, the Emergency Department Physician and Emergency Department Nurse will assume care of the patient and follow the protocols outlined in the Policy.

Interviews

Twenty-one staff members are currently employed at the facility that may have contact with residents. A total of seven residents were in the facility during the site visit. A total of six random residents from the general population were interviewed which included two with Cognitive Disabilities, one residents identified with Physical Disability; one residents who identified as Gay or Bisexual; and two who reported an allegation of sexual abuse during intake. No residents refused. A previous inquiry was made regarding vulnerable categories within the resident population related to the selection of targeted interviews. All targeted resident interviews were conducted as a result of requested lists/documents and conferring with a Counselor.

A number of BNJJC staff provides dual services and roles in the management of the PREA Programs. Thirty-one staff was interviewed to include the CEO and the APC; nine security staff (from all three 8-hour shifts); two administrative staff; two contract staff and 18 specialized staff, and 11 random staff. The random staff members interviewed covered all shifts and specialized staff members interviewed based on their job duties and PREA roles, including two contractors. The Chief Executive Officer (CEO) and the APC were interviewed via telephone; however, they are not counted as specialized staff. Although 12 individuals were identified for specialized interviews, the specialized interviews conducted totaled 16 due to staff members in this category serving in more than one PREA related specialized role.

Volunteers conduct religious services at the facility and coordinate the group of religious volunteers. One contractor provides clinical services. The interviews with residents, staff and contractor indicated their receipt of PREA training which was also verified by a review of documentation, including training materials. Staff and resident interviews were conducted by the Auditor and the interviews conducted onsite were done in the privacy of two different offices.

During this process the Auditor did not limit the interview questions to only those included in the protocols; rather, additional site specific questions were asked to use as a starting point for eliciting information about the facility's compliance with the PREA Standards. All Responses to the interview questions were part of the auditor's compliance assessment. There are no on-site medical providers at the center. Resident interviews support staff's compliance with the facility's prohibition of cross-gender viewing and pat searches. This Auditor was provided evidence to ensure compliance to the PREA as documented in this report.

The Auditors conducted 16 resident interviews in the following categories during the onsite phase of the audit:

Category of Residents	Number of Interviews
Random Residents	6
Residents who Identify as Gay or Bisexual	1
Residents with a Cognitive Disability	2
Residents with Physical Disability	1
Residents Report of Sexual Abuse During Intake	2
Residents who Identify as Transgender or Intersex	0

The Auditors conducted the following number of specialized staff interviews during the onsite phase of the audit:

Category of Staff	Number of Interviews
Medical Staff	1
Mental Health Staff	1
Administrative (Human Resources) Staff	1
Intermediate or Higher-level Facility Staff (unannounced rounds)	2
Volunteers who have Contact with Residents	0
Contractors who have Contact with Residents	2
Investigative Staff	2
Staff who Perform Screening for Risk of Victimization and Abusiveness	6
Staff on the Incident Review Team	2
Designated Staff Member Charged with Monitoring Retaliation	1
Non-Security Staff First Responders	1
Intake Staff	3
Number of Specialized Staff Interviews	18
Number of Random Staff Interviews	11
Total Random and Specialized Interviews	29
Total Interviews plus PREA Coordinator and Director/CEO	31

Onsite Documentation Review

The Auditor received many examples of documentation from resident and staff files as part of the Pre-Onsite Audit Phase. During the Pre-Onsite Audit Phase and the Onsite Audit Phase the Auditor reviewed a sample of personnel files of the staff selected to be interviewed, including documentation of criminal background checks occurring. The PREA Pre-Audit Questionnaire and facility policies, procedures and supporting documentation were reviewed prior to the site visit and while onsite for interviewees and persons not interviewed. The secondary documentation reviewed included, but was not limited to, Vulnerability Assessments, Grievance Form, Medical Request Form, PREA education and training acknowledgement forms, training records, checklists, sexual abuse coordinated response plan, annual staffing plan assessment, staff schedules, unannounced rounds reports, retaliation monitoring form, organization chart, and other documentation. The facility reports there were no allegations of sexual abuse or sexual harassment in the past 12 months.

After the completion of the site visit process, an exit briefing was held in the conference room. The attendees were the facility Superintendent and the Auditor. The exit briefing served to review the onsite process and review program strengths. The Superintendent/PCM was given the opportunity to ask additional questions about the activities of the day and the shared information. The time table for the submission of PREA reports was discussed as well.

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.

The facility, built in 2000, is located at 1400 South Boundary Street, Kirksville, Missouri. The tour of the facility was conducted by the Superintendent who also serves as the facility's PREA Compliance Manager (PCM). The facility is clean, in good repair, and well maintained. This facility is spacious enough for the youth and staff with open hallways and good lighting and located in one building. The tour showed the administration area, control room, medical area, visitation area, supervisors' offices, kitchen, a classroom, and an intake/issuance room. The youth dorms have three living areas (A, B, and C). Dorms "A" and "B" have five rooms in each with a sink and toilets included and are for boys. Dorm "C" has four rooms with a sink and toilet included and is for girls. Each dorm has a shower room with a curtain covering the entrance and a wall blocking view from the outside. There is an outdoor basketball court and an indoor gymnasium.

There are 28 total cameras located on facility grounds. The control room monitors the cameras on a 24-hour basis. The PREA Audit notices were posted on the bulletin boards in various hallways, as well as copies of the PREA brochure written in both English and Spanish (this is the same brochure given to youth during the intake process). Posters containing both the PREA hot-line number and the Child Abuse and Neglect hot-line number (OHI) are prominently displayed.

Summary of Audit Findings

*The summary should include the number of standards exceeded, number of standards met, and number of standards not met, **along with a list of each of the standards in each category**. If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance.*

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

Number of Standards Exceeded: 0

N/A

Number of Standards Met: 43

Based upon the review and analysis of the documentation, interviews and observations, the Auditor has determined the facility is compliant with the PREA Standards for Juvenile Facilities.

Number of Standards Not Met: 0

Summary of Corrective Action (if any)

No Corrective Actions were required.

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.

Documentation Reviewed:
PREA Pre-Audit Questionnaire
Facility Policy 17.1-Prevention Planning Procedures
Organizational Chart
PREA Coordinator's Job Description
2016 Annual Report

Interviews:
Chief Executive Officer (CEO)
Senior Programs Administrator/Agency PREA Coordinator (APC)
Facility Administrator/Superintendent/PREA Compliance Manager (PCM)
Random Staff
Residents

Provision (a):
An agency shall have a written policy mandating zero-tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency's approach to preventing, detecting, and responding to such conduct.

The facility Policy mandates a zero-tolerance policy toward all forms of sexual abuse and sexual harassment. The policy outlines the facility's approach to preventing, detecting, and responding to such conduct. The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment and includes sanctions for those found to have participated in prohibited behaviors. The Policy provides for the appointment of a PREA Coordinator by the Agency CEO.

The Policy addresses detection of sexual abuse and sexual harassment through resident education, staff training, and intake screening for risk of sexual victimization and abusiveness. The Policy includes, but is not limited to, responding to sexual abuse and sexual harassment through reporting, investigations, assessments, crisis intervention, and disciplinary sanctions for residents and staff.

Provision (b):
An agency shall employ or designate an upper-level, agency-wide PREA Coordinator with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities.

The 2016 Annual Report indicated a designated position, Agency PREA Coordinator (APC) and the Facilities PREA Coordinator. The organization chart shows the APC reports directly to the Agency CEO as confirmed by staff interviews. The interview with the APC and the PCM, and observations, revealed that they have the time and authority to perform their PREA duties.

The evidence shows the Agency has designated an upper-level position of PREA Coordinator as verified through the organization chart; Policy; Job Description; review of the PREA Pre-Audit Questionnaire; and the interviews with the CEO and random staff. The PREA Coordinator has demonstrated she has sufficient time and authority to accomplish her PREA related responsibilities.

Provision (c):
Where an agency operates more than one facility, each facility shall designate a PREA compliance manager with sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards.

BNJJC does not contract with another facility to house its residents, according to the Policy and interview with the Agency CEO and the Facility Superintendent.

Conclusion:
Based upon the review and analysis of the available documentation, the Auditor has determined the facility is compliant with this standard requiring a zero-tolerance policy toward sexual abuse and sexual harassment and the designation of a PREA Coordinator.

The BNJJC Policy 17.1-Prevention Planning Procedures meet the mandates of this standard. The Agency's zero tolerance against sexual abuse is clearly established and the policy also outlines the agency's approach to preventing, detecting and responding to sexual abuse and sexual harassment allegations. Zero tolerance posters are displayed throughout the facility. The APC and PCM were interviewed and advised that they have sufficient time and authority to coordinate efforts to comply with PREA standards. Both staff and residents are provided with a variety of opportunities to become aware of the PREA. The review of training records and staff interviews confirmed that staff, volunteers, and contractors, who have regular or frequent contact with residents, receive PREA-related training during initial orientation and annually.

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 OR the response to 115.312(a)-1 is "NO".) ☐ 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.

This standard is N/A. This facility does not contract with other entities for the confinement of youth.

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 agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: 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 only until October 1, 2017.) ☒ 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 only until October 1, 2017.) ☒ 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 only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.) ☒ 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.

Documents Reviewed:
Facility Policy 17.3 PREA Policy-Supervision and Monitoring

Facility Management and Official Counts
Staffing Plan
2017 Staffing Plan Assessment for CTU
Monthly Schedule
Resident Daily Rosters
PREA Pre-Audit Questionnaire

Interviews:
Agency CEO
Facility Superintendent
PREA Coordinator

Provision (a):
The agency shall ensure that each facility it operates shall develop, implement, and document a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, facilities shall take into consideration:
(1) Generally accepted detention and correctional/secure residential practices;
(2) Any judicial findings of inadequacy;
(3) Any findings of inadequacy from Federal investigative agencies;
(4) Any findings of inadequacy from internal or external oversight bodies;
(5) All components of the facility's physical plant (including "blind spots" or areas where staff or residents may be isolated);
(6) The composition of the resident population;
(7) The number and placement of supervisory staff;
(8) Institution programs occurring on a particular shift;
(9) Any applicable State or local laws, regulations, or standards;
(10) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and
(11) Any other relevant factors.

Facility Policy 17.3 provides details for maintaining the staffing ratios. The staffing plan for BNJJC mandates three staff members per shift with one being a female. The 1st shift has three to four staff members, 2nd shift has three to five staff members, and 3rd shift has three to four staff members. PREA training is required of all new hires, as well as PREA refresher courses provided throughout the year to better ensure resident safety. The camera system is monitored constantly and the provisions of the standard are taken into consideration regarding adequate staffing levels as confirmed through the interview with the CEO, the Superintendent and review of staffing plan and observations. The work schedules are based on the staffing plan and facility policy.

Provision (b):
The agency shall comply with the staffing plan except during limited and discrete exigent circumstances, and shall fully document deviations from the plan during such circumstances.

The facility Policy 17.3 states in the event that the staffing ratio is unable to be maintained during exigent circumstances, the deviation must be documented. The facility documents there have been no deviations to the staffing plan in the past 12 months. The facility is prepared to document any deviations from the staffing plan.

Each secure facility shall maintain staff ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances, which shall be fully documented. Only security staff shall be included in these ratios. Any facility that, as of the date of publication of this final rule, is not already obligated by law, regulation, or judicial consent

decree to maintain the staffing ratios set forth in this paragraph shall have until October 1, 2017, to achieve compliance.

Policy17.3 provides for a staff-to-resident ratio of 1:8 during the waking hours and 1:14 during the sleeping hours. The ratio during the sleeping hours may increase but will not be beyond the required ratio of 1:16 during the sleeping hours as indicated by the Policy and the interview with the CEO. The staff-to-resident ratio was in compliance during the site visit as observed during the comprehensive site review. Since the last PREA audit the average daily number of residents is 84. The average daily number of residents on which the staffing plan is predicated is 104.

Provision (c):
Whenever necessary, but no less frequently than once each year, for each facility the agency operates, in consultation with the APC required by § 115.311, the agency shall assess, determine, and document whether adjustments are needed to:
(1) The staffing plan established pursuant to paragraph (a) of this section;
(2) Prevailing staffing patterns;
(3) The facility's deployment of video monitoring systems and other monitoring technologies; and
(4) The resources the facility has available to commit to ensure adherence to the staffing plan.

Policy 17.3 provides, at the least, an annual assessment of the staffing plan is conducted. The Staffing Plan Assessment is conducted annually with the latest being conducted on January 9, 2018 and is signed by the CEO and the APC. The document reviews but is not limited to the following areas prevailing staffing patterns; deployment of video monitoring system; and occurrence of unannounced rounds. Facility Design and Technology, provides that administration in conjunction with the APC assess the video monitoring system at least annually and document the assessment.

BNJJC has 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. Such policy and practice shall be implemented for night shifts as well as day shifts. The policy prohibits 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. A review of a sample of documented unannounced rounds support unannounced rounds are conducted by intermediate level and higher level staff and by Supervisors for each shift at the various times as determined by a review of documentation and interviews. The unannounced rounds conducted by administrative staff are documented on the Unannounced PREA Rounds checklist and the Unannounced Supervisor Rounds checklist is used by shift Supervisors. Areas assessed during the unannounced rounds by the administrative staff includes all areas of the facility such as all living units; common area; staff break room; loading dock; gymnasium; and classrooms. The Supervisors' unannounced rounds include all living units and provides for comments regarding mood, demeanor and interactions. The interview with the APC indicated how she ensures that staff does not alert other staff when she is conducting unannounced rounds. Staff members are not informed of the unannounced rounds and there is not a routine schedule regarding the rounds. Staff members are encouraged not to alert other staff members regarding the unannounced visits.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is in compliance with this standard regarding supervision and monitoring.

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 implement policies and 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.

Documents Reviewed:
Facility Policy 17.4, PREA Policy Limits to Cross Gender Viewing and Searches
Facility Policy 11.7 Security and Control
PREA Pre-Audit Questionnaire
Training Acknowledgement Statements
Training Sign-in Sheet
Resident Pat Down Searches & Control of Contraband Accountability Form
Resident Handbook
Posted Signs

Interviews:
Facility Superintendent
PREA Coordinator
Random Staff
Residents

Provision (a):
The facility shall not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by medical practitioners. Facility Policy 8.12, Resident Searches, prohibit cross-gender strip searches and cross-gender visual body cavity searches. There is no evidence of cross-gender strip searches or cross-gender visual body cavity searches occurring at the facility. Based on the review of the Pre-audit questionnaire and according to the Superintendent, no such searches have been conducted.

Provision (b):

The agency always refrains from conducting cross-gender pat-down searches of female residents, except in exigent circumstances. In addition, the agency shall always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision.

BNJJC Policy 17.4 provides that staff will only conduct cross-gender pat-down searches of females only in exigent circumstances. Additionally, the search must be approved by the Superintendent and the justification for the search must be documented. The facility provides training on how to conduct these searches in exigent circumstances using training curricula. Staff participation in the training is recorded with training sign-in sheets and training acknowledgement statements. Staff interviews confirmed they are aware of the restriction of conducting cross-gender pat-down searches except in exigent circumstances.

No male residents interviewed reported a female staff member conducted a pat-down search of their body. The evidence shows cross-gender pat-down searches have not occurred at the facility, but the facility is prepared for them to be conducted in exigent circumstances. Based on the review of the Pre-audit questionnaire; staff and resident interviews; training sign-in sheets; and training acknowledgement statements, the facility follows this provision of the standard.

Provision (c):
The facility shall document and justify all cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches.

The Policy prohibits cross-gender strip searches and cross-gender visual body cavity searches. Cross-gender pat-down searches may be conducted only in exigent circumstances which random staff interviews summarized as an extreme emergency. BNJJC Policy 17.4 indicates that in the event a cross-gender search is warranted pursuant to an emergency circumstance, it must be approved by the CEO and the justification for the search documented. Such searches will be documented on a form currently used for all searches which have been used for same sex searches. The form requires the staff to record the reason for the search. The evidence shows the facility is prepared to document and justify all cross-gender pat-down searches. Based on the review of the Pre-audit questionnaire and the Resident Pat Down Searches & Control of Contraband Accountability Form, staff and resident interviews, and staff training materials, the facility follows this provision of the standard.

Provision (d):
The facility shall implement policies and 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. Such policies and procedures shall require staff of the opposite gender to announce their presence when entering a resident housing unit. In facilities (such as group homes) that do not contain discrete housing units, staff of the opposite gender shall be required to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing.

BNJJC Policy 17.1 states the facility will enable residents to shower, perform bodily functions, and change clothes without non-medical staff of the opposite gender viewing them except in exigent circumstances or during routine room checks. Staff members of the opposite gender are required to knock and/or announce themselves upon entering the unit. This practice was confirmed through observation of signage indicating such, observations and interviews with residents and staff. No resident interviewed reported ever having been naked in full view of female staff while showering, changing clothing, and performing bodily functions. The evidence shows residents shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia. Based on the review of the documentation, staff and resident interviews,

and observations, the facility follows this provision of the standard. Additionally, viewing of the cameras and staff and resident interviews confirmed that residents are not directly viewed by staff when showering, using the toilet or changing clothes.

Provision (e):
The facility shall not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner.

BNJJC Policy 11.7 prohibits the search of transgender or intersex residents solely for the purpose of determining the residents' genital status and staff interviews verified no such searches have occurred in the past 12 months. According to the Policy, if the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or by learning that information as part of a broader medical examination conducted in private by a medical practitioner. One hundred percent of BNJJC staff received the training on conducting cross-gender pat-down searches and searches of transgender and intersex residents. Staff interviews confirmed they are aware facility policy prohibits them from conducting a physical examination of transgender or intersex resident solely for the purpose of determining the resident's genital status. Based on the documentation reviewed and staff interviews, the facility meets this provision of the standard.

Provision (f):
The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

BNJJC Policy 17.1 states that staff shall be trained in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. The documentation and staff interviews support the training is conducted at least annually. Training participation is documented with sign-in sheets and training acknowledgement forms. The evidence shows staff are trained in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

Conclusion:
Based on the reviewed documentation and interviews, the facility follows this provision of the standard.

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.

Documents Reviewed:
Facility Policy 17.5 Residents with Disabilities and/or Limited English Proficient.
Memorandum from Juvenile Services Supervisor, Division of Court Program Access to Interpreter
Admission Summary Overview forms
Resident Handbook in English and Spanish

Interviews:
Residents
Random Staff
PREA Coordinator
Contractor

Provision (a):
The agency shall take appropriate steps to ensure that residents with disabilities (including, for example, residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech 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. Such steps shall include, when necessary to ensure effective communication with residents who are deaf or hard of hearing, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. In addition, the agency shall 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, limited reading skills, or who are blind or have low vision. An agency is not required to take actions that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens, as those terms are used in regulations promulgated under Title II of the Americans With Disabilities Act, 28 *CFR* 35.164.

The facility Policy addresses the provision of support services for disabled residents by providing these residents the equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The 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, performance of first responder duties, or the investigation of the allegations. Staff interviews and an interview with a contractor confirmed this information.

During resident interviews the accommodations of transcribed and narrated educational material, particularly, textbooks for visually impaired resident were discussed. The interview revealed residents understanding of the PREA information. Two residents with cognitive disabilities were interviewed and their interviews revealed an understanding of the information covered in the PREA education sessions.

Provision (b):
The agency shall 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, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary.

A language line Solution is available and can be accessed by staff 24/7. The Resident Handbook is in English and Spanish. The evidence shows residents with disabilities and who may be limited English proficient are provided 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. All staff interviewed confirmed residents are not used as interpreters and understand prior arrangements have been made regarding language interpreters. The Resident Handbook is printed in English and Spanish. The PREA audit notice was printed in English and Spanish. The evidence shows the facility ensures 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, including taking steps to provide interpreters who can interpret effectively, accurately, and impartially, using any necessary specialized vocabulary.

Provision (c):
The agency shall not rely 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.

According to Policy 17.5, the facility prohibits the use of resident interpreters, resident readers or any kind of resident assistants except when a delay in obtaining interpreter services could jeopardize a resident's safety, performance of the first responder duties, or the investigation of the allegation. Staff interviews confirmed residents have not been used to relate PREA information to or from other residents in the past 12 months. There were no residents in need of an interpreter during the site visit.

Conclusion:
Based upon the review and analysis of the evidence, the Auditor has determined the facility is compliant with this standard regarding residents with disabilities and residents who are limited English Proficient. Residents with disabilities and who are limited English Proficient are provided 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.

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, or 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)

- Unless prohibited by law, 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.

Documentation Reviewed:
Facility Policy 17.1 Hiring and Promotion
Facility Policy 3.2, Court Operating Rule 7; Employee Background Investigations Checks
Missouri Department of Social Services Application for Employment – BNJJC Secure Detention Addendum
Personnel Files

Interviews:
Administrative (Human Resources Manager)
Superintendent
Staff

Provision (a) & (f):
(a) The agency shall not hire or promote anyone who may have contact with residents, and shall not enlist 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.
(f) The agency shall also 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 and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.

Facility Policy addresses hiring and promotion processes and decisions and background checks. The Policy is aligned with the requirements of the provisions of the standard and provides background checks occur prior to employment and every five years thereafter. Initial background checks and five-year checks were reviewed while on site. Additional personnel information reviewed during the pre-audit and the onsite audit phases included: Missouri Department of Social Services Application for Employment – BNJJC Secure Detention Addendum; Pre-Hire Interview Questions; New Hire Application Packet and Current Staff Applications. The interview with the Superintendent and a review

of Policy provide details about the hiring process, completion of background checks, and the grounds for termination in accordance with the PREA standard. According to the interview, staff has a continuing duty to report related misconduct and omission of sexual misconduct or providing false information will be grounds for termination. The forms completed and included in the personnel files are in response to the above provisions of this standard.

According to facility Policy, all applicants are asked about any prior misconduct involving any sexual activity. In addition, Missouri Department of Social Services and BNJJC shall not hire or promote anyone who has been civilly or administratively adjudicated to have been convicted of engaging in or attempted to engage in sexual activity by any means. Also, the agency does not hire anyone who has engaged in sexual abuse in a prison, jail, community confinement facility, or anyone, who has used or attempted to use force in the community to engage in sexual abuse.

Provision (b):
The agency shall consider any incident of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

The facility Policy states any incidents of sexual harassment by a staff member will be taken into consideration if the staff member is eligible for promotion. The interview with the Superintendent was aligned with the standard. The interview questions for employment also address previous misconduct. The evidence shows the facility considers any incident 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. Based on the review of the personnel files, records provided during the pre-audit phase, and the interview with the Superintendent, the facility follows this provision of the standard.

Provisions (c) & (d):
(c) Before hiring new employees or (d) contractors who may have contact with residents, the agency shall:
(1) Perform a criminal background records check;
(2) Consult any child abuse registry maintained by the State or locality in which the employee would work; and
(3) 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.

The agency policy requires background checks to occur prior to residents receiving services from contractors and volunteers and confirmed by the Superintendent's interview. Additionally, best efforts should be made 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. Based on the review of documentation and interview with the Superintendent, the facility follows this provision of the standard.

Provision (e):
The agency shall 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.

The agency policy is aligned with the requirements of the provisions of the standard and provides background checks occur prior to employment and every five years thereafter. Initial background checks and five-year checks were reviewed while onsite and during the pre-audit phase. This was also confirmed during the Superintendent's interview. Based on the review of documentation and the interview, the evidence shows the facility practices are aligned with the provisions of this standard.

Provision (g):
Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

Facility Policy 3.2 states material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. Based on the review of the documentation and the interview with the Superintendent, the evidence shows the facility follows this provision of the standard.

Provision (h):
Unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work.

The interview with the Superintendent confirmed the facility would provide this information if requested to do so. Facility Policy 3.2 also states the information would be provided when requested unless it is prohibited by law to provide the information.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with the provisions of the standard regarding hiring and promotion decisions.

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 interview with the Superintendent and according to the Pre-Audit Questionnaire, no substantial modification to the facility or upgrades to the camera system occurred since the last PREA audit in 2016. Facility Policy 17.3, Supervision and Monitoring states that when there is substantial expansion to the facility, the ability to protect residents and staff from sexual abuse will be reviewed and ensured.

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 evidentiarily 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? ☒ Yes ☐ No

- 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 entity 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? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.) ☒ 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.

Documents Reviewed:
Facility Policy 17.8 Response Planning and Investigation
Court Operating Rule 7 Section B and Policy and Procedure Section 2 and 3
Rainbow House Regional Child Advocacy Center Sexual Assault Policy and Protocols
Memorandum of Understanding for Child Abuse Resource and Education (SAFE-CARE) providers and Child Advocacy Centers (CAC)
Children's Mercy Hospital SCAN Clinic Protocol
Resident Handbook

Interviews:
Children's Division Supervisor
Child Advocacy Administrative Executive Director, Rainbow House
Superintendent/PCM
PREA Coordinator

Provisions (a) & (b):
(a) To the extent the agency is responsible for investigating allegations of sexual abuse, the agency shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. (b) The protocol shall be developmentally appropriate for youth and, as appropriate, shall be 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.

Agency policy, Court Operating Rule 7 Section B and Policy and Procedure Section 2 and 3, provides for the uniform Protocols to be followed. The Protocol is outlined regarding appropriateness for youth and adults. The facility does not conduct administrative or criminal investigations according to Court Operating Rule 7 Section B and Agency PREA Policies Section 2 and 3. Referrals are made to Child Abuse and Neglect (OHI) who conducts administrative investigations and to the Kirksville Police Department, who conducts criminal investigations. Forensic medical exams, when needed, would be conducted at the Northeast Regional Medical Center in Kirksville, Missouri. Forensic exams would be conducted at no cost to the youth or their family. No forensic medical exams were conducted during the

previous 12 months. A review of an email dated June 17, 2015 from the Interim Executive Director of Rainbow House verified the facility has an agreement with the Victim Support Services – Rainbow House offering victim advocate services. Staff interviews confirmed an understanding of the facility's protocol for obtaining usable physical evidence if a resident alleges sexual abuse and knowledge of the entities responsible for conducting investigations.

Provision (c):
The agency shall 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. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs.

The Policy states forensic medical examinations will be conducted at Northeast Regional Medical Center in Kirksville, Missouri, who employs Sexual Assault Nurse Examiners (SANE) and Sexual Assault Forensic Examiners. The Sexual Assault Policy of the Hospital states that the medical forensic examination will be conducted by a SANE or SAFE. The facility Policy states that the services will be provided at no cost to the victim. The Nurse's interview was aligned with the facility Policy.

Provisions (d) & (e):
(d) The agency shall attempt to make available to the victim a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the agency shall make available to provide these services, a qualified staff member from a community-based organization or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified in 42 U.S.C. 14043g(b)(2)(C), to victims of sexual assault of all ages. The agency may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a nongovernmental entity that provides similar victim services. (e) As requested by the victim, the victim advocate, qualified agency staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals.

According to the agreement, with the Victim Support Services – Rainbow House, the supportive services to victims include access to 24-hour reporting and contact for advocacy service; emotional support; accompaniment through forensic examination and investigative interview upon request; and provision of information and resources. The Program Manager confirmed that advocacy services will be provided in accordance with the agreement. The interview with the PCM confirmed the resident and/or facility staff members are able to utilize the hotline to request a victim advocate.

Provisions (f) & (g):
(f) To the extent the agency itself is not responsible for investigating allegations of sexual abuse, the agency shall request that the investigating agency follow the requirements of paragraphs (a) through (f) of this section. (g) The requirements of paragraphs (a) through (f) of this section shall also apply to: (1) Any State entity outside of the agency that is responsible for investigating allegations of sexual abuse in juvenile facilities; and (2) Any Department of Justice component that is responsible for investigating allegations of sexual abuse in juvenile facilities.

Allegations of sexual abuse that are criminal in nature are conducted by the Kirksville Police Division. The MOU states that the Police Division will follow the agency protocol regarding sexual abuse/assault investigations. Agency policy, Court Operating Rule 7 Section B and Policy and Procedure Section 2

and 3, provides for the uniform Protocols to be followed. The Protocol is outlined regarding appropriateness for youth and adults.

Provision (h):
For the purposes of this standard, a qualified agency staff member or a qualified community-based staff member shall be an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general.

The facility has an agreement with the Victim Support Services – Rainbow House offering victim advocate services. The Program Manager states that her staff has certification for completing their PREA Victim Support Staff Training. The Executive Director of Rainbow House stated that staff are trained to provide supportive services to victims include access to 24-hour reporting and contact for advocacy service; emotional support; accompaniment through forensic examination and investigative interview upon request; and provision of information and resources.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is in compliance with the provisions of this standard.

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 such publication 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.

Documents Reviewed:
Facility Policy 17.8, Responsive Planning and Investigations
Facility Policy 2.7 Administration – Reporting Allegations of Abuse or Neglect
Facility Policy 3.1 Administration – Personnel Management
Court Operating Rule 7 Section B and Policy and Procedure Section 2 and 3
Resident Handbook
Pre-Audit Questionnaire

Interviews:
OHI Investigator
Superintendent/PCM
PREA Coordinator
Random Residents
Random Staff

Provision (a):
The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.

The Policy directs staff to report all allegations of sexual abuse and sexual harassment and to document the reports. Staff members are aware of the Policy requirements as verified through their interviews. The facility reports no allegations of sexual abuse and one allegation of sexual harassment. The facility Policy and the MOU ensures the cooperation between the facility staff and the Bowling Green Police Division. The letter from the Police Chief discusses the training and experience of investigators that may be assigned to conduct investigations.

Provision (b) and (c):
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. (c): If a separate entity is responsible for conducting criminal investigations, such publication shall describe the responsibilities of both the agency and the investigating entity.

Agency Policies 2.7 and 3.1 detail a comprehensive set of procedures to ensure that administrative or criminal investigations are completed for all allegations of sexual abuse and sexual harassment. This policy describes the responsibilities of both the facility and the investigating agencies. This was verified in the interview with the Agency Head. For all cases of suspected abuse or neglect, a call shall be made to Child Abuse and Neglect (OHI) immediately or as soon as possible after learning of the incident. If the allegation involves potentially criminal behavior, the Superintendent or designee shall contact local law enforcement. All incidents shall be documented in an Informational Incident Report. There were no PREA-related allegations made during the previous 12 months. Staff interviews and training documentation confirmed that all staff have been trained on their responsibilities as mandatory child abuse reporters and understand their responsibilities to call OHI and local law enforcement (i.e., Kirksville Police Department) for sexual abuse incidents or suspicions.

The facility's website provides the information and related policies for reporting allegations of sexual abuse. A third-party reporting form is also on the website. Reporting information is also posted in various areas of the facility including but not limited to living units. The posted information is accessible to residents, staff, contractors and visitors. The Policy and interviews confirmed allegations of sexual abuse and sexual harassment are investigated. Administrative investigations are conducted by the trained facility investigators and sexual abuse allegations that are criminal in nature are investigated by the Kirksville Police Department.

Provision (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 facility and the Kirksville Police Department have policies and a MOU governing investigations.

Provision (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.

The Department of Justice is not responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment at BNJJC.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding policies to ensure referrals of allegations for investigations.

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.

Documents Reviewed:
Facility Policy 17.9, Training and Education
Facility Policy 5.2, Training and Education-New Personnel Orientation/Familiarization
Facility Policy 5.4, Training and Education-Training within First Year of Employment
Yearly Training Agreement
Employee PREA Training Summary Log
Training Attendance Record (Sign-in Sheets)

Interviews:

Random Staff
APC

Provisions (a) and (c):
All employees shall be provided information on the agency's zero tolerance of sexual abuse and sexual harassment of offenders and an overview of staff duties to meet PREA requirements. Documentation of receipt of the information and training shall be maintained in the employee training file.

The agency shall train all employees who may have contact with residents 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; and
(10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities;
(11) Relevant laws regarding the applicable age of consent.
All current employees who have not received such training shall be trained within one year of the effective date of the PREA standards, and the agency shall 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. In years in which an employee does not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies.

All BNJJC Division of Correctional Services (DCS) employees shall be provided a BNJJC brochure that describes PREA, BNJJC's zero-tolerance of sexual abuse and sexual harassment of offenders and an overview of staff duties to meet PREA requirements. Documentation of receipt of the brochure shall be maintained in the employee training file.

The facility Policy addresses PREA related training for staff. All interviewed staff members were familiar with the PREA information regarding primary components of preventing, detecting and responding to sexual abuse or sexual harassment. PREA training is provided to staff, as indicated by a review of Policy and training documents. The documents and staff interviews support refresher training is also conducted and is documented.

The BNJJC staff interviewed and the APC reported the training is provided as required. All BNJJC staff members interviewed and document review verified the general topics identified in the PREA Standard identified above were included in their training. The Policy, training materials, staff interviews, review of the trainings log and acknowledgement statements verify the staff training occurs. Training is conducted annually and refresher training is provided as needed. Staff interviews confirmed they have received training on the 11 required topics.

The evidence shows staff members are provided all of the required training topics. Based on the review of the Pre-audit questionnaire, training curriculum, associated training materials and records, and staff interviews, the facility complies with the provisions of the standard.

Provision (b):
Such training shall be tailored to the unique needs and attributes of residents of juvenile facilities and to the gender of the residents at the employee's facility. The employee shall receive additional training if the employee is reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa.

The facility houses males and females and the training considers the needs of the population as determined by a review of training curricula and interviews with random staff. The Policy state the training shall be tailored to the needs and attributes to the population served.

Provision (d):
The agency shall document, through employee signature or electronic verification that employees understand the training they have received.

The Policy provides all training be documented. Staff members sign training rosters and training acknowledgement statements. A checklist is utilized for orientation training for all new employees and contains the elements of PREA training. The facility provided the Auditor with several examples for verification of the training occurring and the training was verified through staff interviews. The facility follows this provision of the standard.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is following the provisions of this standard.

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.

Documents Reviewed:
Facility Policy 17.9, Training and Education
Bruce Normile Secure Detention Unit Fundamental Practices Employee/Volunteer Agreement
Contract/Volunteer PREA Training Summary Log
Contract/Volunteer Guideline Agreement Summary Log
Training Attendance Record (Sign-in Sheets)

Interviews:
Contractors
Superintendent/PCM

Provision (a):
The agency shall ensure 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.

The Policies require volunteers and contractors who have contact with residents, be trained on PREA and their responsibilities regarding sexual assault prevention, detection, and response to allegations of sexual abuse and sexual harassment. A review of training records and interviews document the training occurs.

Provision (b):
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.

The interviews revealed the PREA training informs the participants of their role in reporting allegations of sexual abuse and sexual harassment. The participants are informed of their responsibilities regarding sexual abuse prevention, detection, and response to a PREA allegation. The training is based on the services provided by the contractors and volunteers. The contractors and volunteers also stated the training includes a review of the zero-tolerance policy regarding sexual abuse and sexual harassment of residents.

Provision (c):
The agency shall maintain documentation confirming that volunteers and contractors understand the training they have received.

The PREA Volunteer Guideline Agreement contains the information reviewed with the contractor and volunteer. The document also serves as the training acknowledgement statement containing the signature of the participant and the date, confirming their understanding of the PREA information.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with the provisions of this standard regarding volunteer and contractor training. Policy 5.4 meets the requirements of the standard. The facility utilizes volunteers and contractors, who are required to complete the same comprehensive PREA training. The volunteer and/or contracted staff signs a Fundamental Practices Employee Agreement and Volunteer Guideline Agreement Documentation. The agreement form was all reviewed by this Auditor. Staff interviews and files verified the training completion.

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 such education? ☒ 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.

Documents Reviewed:
Facility Policy 6.3 Resident Intake and Admission

Facility Policy 17.9, Training and Education
PREA Education Safety First Lesson Plan
Safety Brochure
Juvenile PREA Intake Orientation Acknowledgement
Resident Handbook
Posters Observed

Interviews:
Residents (3 Random and 3 Targeted interviews)
Intake Staff
Contractors

Provisions (a) and (b):
During the intake process, residents shall receive information explaining, in an age appropriate fashion, the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. (b): Within 10 days of intake, the agency shall provide comprehensive age-appropriate education to residents either in person or through video 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.

Facility Policy provides all residents admitted receive information about the facility, including PREA education. Residents receive directions on how to report allegations of sexual abuse and sexual harassment; and the right to be free from retaliation for reporting. According to the Superintendent and the residents interviewed, an orientation is provided to residents during the intake process. Policy provides that residents receive a comprehensive age-appropriate PREA education session within 10 days of admission to the facility. The results of the staff and resident interviews indicated the information provided to the residents is comprehensive and age-appropriate.

The intake staff's interview revealed 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. The PREA education sessions include a review of the Safety Brochure. The residents sign acknowledgement statements confirming their receipt of the PREA information. A review of documentation showing dates and indicating residents' participation in PREA education sessions confirmed the PREA education sessions occur. The PREA-related information is provided to staff in policies and procedures, training and staff meetings.

Provision (c):
Current residents who have not received education prior to arrival at the facility shall be educated within one year of the effective date of the PREA standards, and shall 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.

The Intake staff was interviewed regarding PREA education for residents transferred to BNJJC. Available documentation reviewed indicated that residents' receipt of the information, including the resident signing the acknowledgement form.

Provision (d):
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.

The facility has the capability to provide the PREA education in formats accessible to all residents including those who may be hearing impaired; deaf; have intellectual, psychiatric and speech disabilities; low vision; blind; limited reading, limited English proficient, and based on the individual need of the resident. Posted PREA information is in English and Spanish accessible to residents, staff, contractors, volunteers, and visitors. Staff interviews confirmed residents are not used as translators or readers for other residents. Residents with cognitive disabilities revealed and understanding of the PREA information provided.

Provision (e):
The agency shall maintain documentation of resident participation in these education sessions.

A sample of signed acknowledgement statements were reviewed which supported the residents' involvement in PREA education sessions. The residents were aware of PREA information, including their rights regarding PREA, how to report allegations and that they would not be punished for reporting allegations of sexual abuse or sexual harassment. The PREA Compliance Manager was interviewed regarding PREA education for residents. The PREA Compliance Manager ensures residents' receipt of the information, including the resident signing the acknowledgement form.

Provision (f):
In addition to providing such education, the agency shall ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats.

The PREA education materials provide residents information on how to report allegations of sexual harassment and sexual abuse. A brochure is provided to each resident to eliminate incidents of sexual abuse and sexual harassment. The brochure provides educational information regarding sexual abuse and victims. The residents revealed they can report allegations of sexual abuse or sexual harassment by telling a staff member; telling a family member who may report the allegation for them; access to the hotline to report allegations of sexual abuse or sexual harassment; or complete a grievance form. Each resident is provided a Handbook and Safety Brochure. Posters were observed placed throughout the facility and were easy to see and read.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with the provision of this standard. Policies 7.9 and 9.4 address youth orientation and education. During intake, all youth receive an orientation that includes the PREA information relating to sexual misconduct and abusive sexual contact. The information is available in English and Spanish. Interpretive services for other languages are available, if needed. Interviews with youth confirmed that the information is communicated orally and in written form; and that they understood the information presented.

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.

Not applicable. BNJJC staff does not conduct sexual abuse investigations and shall refer all such matters to outside law enforcement agencies. Child Abuse and Neglect (OHI) will conduct administrative investigations into PREA related allegations. All Investigators complete investigator training to enhance their skills. Interviews confirm this practice.

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? ☒ Yes ☐ No

- 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? ☒ Yes ☐ No

- 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? ☒ Yes ☐ No

- 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? ☒ Yes ☐ No

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.) ☒ 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? ☒ Yes ☐ No

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? ☒ Yes ☐ No

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? ☒ 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.

Not applicable. BNJJC does not rely on medical and mental health care practitioners to work regularly in the correctional facility and shall refer residents needing such services to appropriate practitioners in the community. Interviews with contracted medical and mental health staff confirmed they received additional specialized training.

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: Prior sexual victimization or abusiveness? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: 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: Current charges and offense history? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Age? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: 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.

Documents Reviewed:
Facility Policy 6.4, Intake and Admission-Orientation for newly admitted Juveniles
Missouri Secure Detention Sexual Assault Victim/Assailant Checklist (SAVAC)
PREA Education & Screening Log
PREA Documents Summary Log

Interviews:
PREA Coordinator
Staff Responsible for Risk Screening
Residents

Provision (a):
Within 72 hours of the resident's arrival at the facility and periodically throughout a resident's confinement, the agency shall obtain and use information about each resident's personal history and behavior to reduce the risk of sexual abuse by or upon a resident. The Policy provides a risk screening occurs within 72 hours upon arrival to the facility. The Intake Coordinator will interview the resident at intake to obtain information about the resident's personal history and behavior in order to reduce the risk of sexual abuse by or upon a resident. The resident's risk level is reassessed periodically.

Policy 6.4 addresses risk screening. All youth are screened upon arrival for potential risk, utilizing the Admission and Placement Screening for Detention Centers, which contains the elements required by the standard. If the result from the Risk Assessment Tool indicates a probability for victimization or sexually aggressive behavior and/or violent behavior, the youth shall be assigned to an appropriate room close to staff posts. If the screening indicates that a youth has experienced prior victimization or has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, the intake staff shall offer the youth a follow-up meeting with a facility Mental Health specialist. The follow-up shall be completed within 14 days. The Intake staff also completes an inspection of any other medical and mental health screenings that may have been conducted, as well as conversations with the youth during the admission process. Existing court records and case files are also consulted, if available. Policy requires intake staff, as part of the risk screening process, to attempt to ascertain information about any gender non-conforming appearance, mannerisms, or identification as LGBTQI. All risk assessment documentation is securely maintained and accessible only on a need to know basis. Youth are assessed as needed, at least every 30 days, and more specifically if a youth makes an allegation of sexual abuse or harassment the entire screening is re-conducted. Files showed

that all screenings were conducted within 24 hours of intake. Youth interviews confirmed that they received a risk screening during the admission process. Interviews with Specialized Staff who perform the risk screenings confirmed the comprehensive nature of the screenings and how housing decisions were made.

Disclosure of prior victimization or perpetrated sexual abuse is addressed during the time of disclosure. The information is related to mental health personnel following the disclosure of the information. There was one resident in the facility who had disclosed prior victimization. A review of documentation, interviews with residents and staff confirmed the Vulnerability Assessment is administered. The information for the instrument may be obtained by asking questions from the form, medical and mental health screenings and other methods. All residents interviewed could identify specific areas inquired about in the administration of the Vulnerability Assessment. Reassessments are conducted periodically. PREA Education and Screening log was reviewed and it is maintained indicating the administration of the initial assessment and the completion of the follow-up assessments.

The facility provided the Auditor with examples of the screening tool. The PCM, responsible for monitoring risk screening, confirmed residents are screened whether a new admission or transfer from another facility for risk of sexual abuse victimization or sexual abusiveness toward the other residents. The risk screening occurs within 72 hours of intake, usually on the first day. Risk levels are reassessed periodically per the Intake staff and a review of documents. All residents interviewed entered the facility within the past 12 months. They confirmed they were asked questions like the following examples at intake:
(1) Have you have ever been sexually abused?
(2) Do you identify with being gay, bisexual or transgender?
(3) Do you have any disabilities?
(4) Do you think you might be in danger of sexual abuse at the facility?

Based on the review of the Pre-audit questionnaire, review of resident records, interview with the staff responsible for risk screening, and resident interviews, the evidence shows that resident's risk levels are assessed during intake, but no later than 72 hours of their arrival at the facility. Additionally, risk levels are reassessed periodically. The facility follows this provision of the standard.

Provision (b):
Such assessments shall be conducted using an objective screening instrument.

The Vulnerability Assessment is used to obtain the information required by the standard, including but not limited to prior sexual victimization or abusiveness; self-identification; current charges and offense history; intellectual or developmental disabilities; and a resident's concern regarding his own safety. The interview and review of Policy revealed how the objective instrument is administered to glean information to assist staff in keeping residents safe. The responses on the instrument garner a score and the risk level is determined by definition and the corresponding number to that definition. The Policy states residents will be screened within 72 hours of admission; however, interviews with residents indicated it is also administered earlier.

Provision (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 Auditor reviewed the Missouri Secure Detention Sexual Assault Victim/Assailant Checklist (SAVAC) screening instrument and determined all factors required by this provision of the standard are included. The interview with the PREA Compliance Manager confirmed she is aware of the elements of the risk screening instrument. The resident interviews also confirmed the administration of the screening instrument.

Provision (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 facility Policy states the 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 file. The staff and resident interviews are aligned with the Policy and this provision of the standard. The review of the instrument and interview with the PREA Compliance Manager responsible for risk screening confirmed the information is ascertained through conversations with the residents using the Vulnerability Assessment: Risk of Victimization and/or Sexual Aggression screening instrument. Resident interviews also revealed the instrument is used. Additional screening instruments are used and based on the needs of the resident.

Provision (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 Policy provides for appropriate controls be taken to ensure that sensitive information is protected and not exploited. A letter from the Director states controls are in place. Interview revealed the information is only available to the PREA Compliance Manager and the mental health staff. The documents are kept in the resident's file in a locked file cabinet in the locked office when unoccupied by the PREA Compliance Manager. The Auditor observed the files to be maintained in a secure manner. The evidence shows the facility follows this provision of the standard.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is fully compliant with this standard regarding screening for risk of victimization and abusiveness.

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? ☒ Yes ☐ No

- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? ☒ Yes ☐ No

- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? ☒ Yes ☐ No

- Do residents in isolation receive daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- Do residents also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.342 (c)

- Does the agency always refrain from placing: Lesbian, gay, and bisexual 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 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 paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?) ☒ Yes ☐ No ☐ NA

- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?) ☒ 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? ☒ 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.

Documents Reviewed:
Facility Policy 17.10, Screening for Risk of Sexual Victimization and Abusiveness
Facility Policy 2.7, Bruce Normile Juvenile Justice Center Standard of Operations Procedures-Administration
Facility Policy 9.6, Bruce Normile Juvenile Justice Center Standard of Operations Procedures-Rules and Discipline
Pre-Audit Questionnaire

Interviews:
Resident
PREA Compliance Manager
Superintendent
Staff Responsible for Risk Screening/Intake
Random Staff

Provision (a):
The agency shall use all information obtained pursuant to § 115.341 and subsequently to make housing, bed, program, education, and work assignments for residents with the goal of keeping all residents safe and free from sexual abuse.

The facility Policy provides guidance to staff regarding the use of the information obtained from the Vulnerability Assessment: Risk for Victimization and/or Sexual Aggressiveness. The staff interviews and information obtained through the administration of the screening instrument assist in determining bed, education and other program assignments with the goal of keeping all residents safe and meeting the needs of each resident. This information was verified through a review of specific samples of the aforementioned completed screening instrument. The facility also uses additional screening instruments.

Provision (b):
Residents may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping

all residents safe can be arranged. During any period of isolation, agencies shall not deny residents daily large-muscle exercise and any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible.

The Policy states any use of segregated housing to protect a resident who is alleged to have suffered sexual abuse shall comply with § 115.342 and the provision (a). At no time will any client be denied any legally required educational programs, special education services, daily large-muscle exercise, or medical/mental health care. At risk residents may only be placed in isolation in an emergency situation, and only as a last resort if less restrictive measures are inadequate to keep the resident safe.

No residents at risk of sexual victimization were placed in isolation in the 12 months preceding the audit. The interview with the Superintendent confirmed the facility has not used isolation for this purpose. The policy is inclusive of this provision if there were to be an emergency situation. The use of isolation would be documented. The residents' rights to daily large-muscle exercise and any legally required educational programming or special education services would be provided. Based on the review of the Pre-audit questionnaire, related documents and interview with the Superintendent, the evidence shows the facility follows this provision of the standard.

Provision (c):
Lesbian, gay, bisexual, transgender, or intersex residents shall not be placed in particular housing, bed, or other assignments solely on the basis of such identification or status, nor shall agencies consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

The Policy prohibits placing lesbian, bisexual, transgender, or intersex residents in specific housing or making other assignments solely based on how the residents identify or their status. The Policy prohibits staff from considering the identification as an indicator that these residents may be more likely to be sexually abusive. During the comprehensive site review, there were no rooms observed to be reserved for transgender or intersex residents. The restroom/showers were observed and were configured for a reasonable amount of privacy. A targeted resident interview revealed there is no special housing based on how a resident identifies, which was also supported by staff interviews and observations.

Provision (d):
In deciding whether to assign a transgender or intersex resident to a facility for male or female residents, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems.

The Policy also provides that housing and program assignments for transgender or intersex residents would be made on a case-by-case basis and these residents would not be placed in particular or special housing which was evident from staff interviews. There were no transgender or intersex residents in the facility during the site visit and this audit period. The PREA Compliance Manager's interview confirmed the facility would consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems.

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

The Policy states placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year. This function would be done to review any threats to safety experienced by the resident and the PREA Compliance Manager is aware of the requirement. The PREA Compliance Manager confirmed each transgender or intersex resident would be reassessed at least twice each year to review any threats to safety experienced by the resident. Based on the review of the Pre-audit Questionnaire and interview with the PREA Compliance Manager, the evidence shows the facility follows this provision of the standard.

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

The Policy states transgender or intersex residents shall be given the opportunity to shower separately from other residents which is also supported by staff interviews.

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.

The Policy states if a resident is isolated pursuant to part (B.2.) of this section, the facility shall document:
(a.) The basis for the facility's concern for the resident's safety; and
(b.) The reason why no alternative means of separation can be arranged.

No residents at risk of sexual victimization were placed in isolation in the 12 months preceding the audit. Interviews with the Superintendent and APC confirmed the facility has not used isolation for this purpose. The policy is inclusive of this provision if there were to be an emergency situation. The Isolation/separation would be documented according to the provisions of the Policy and standard.

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

The Policy states every 30 days, staff shall afford each resident described in provision (b) of this section a review to determine whether there is a continuing need for separation from the general population. No residents at risk of sexual victimization were placed in isolation in the 12 months preceding the audit. Interviews with the Superintendent and APC confirmed the facility has not used isolation for this purpose. The policy is inclusive of this provision if there were to be an emergency situation.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is fully compliant with this standard regarding use of screening information. The 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. The facility prohibits placing LGBTI residents housing, bed, or other assignments solely on the basis of such identification or status and does not consider such identification or status as an indicator of likelihood of being sexually abusive. The facility is prepared to provide a safe and secure environment and follow all provisions of this standard.

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? ☒ Yes ☐ No

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.

Documents Reviewed:
Facility Policy 17.11, Reporting of PREA Violations
Juvenile PREA Intake Orientation Acknowledgement
Detention Unit Rules and Expectations Compliance Agreement
Grievance Forms
Medical Request Form
Third Party Reporting Forms
Safety Pamphlet
Sample of Incident Report
Resident Handbook
Observed PREA Posters

Interviews:
Random Staff
Residents
Superintendent/PCM

Provision (a):
The agency 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. BNJJC policy covers this standard. For the reporting duties and confidentiality section A covers it. Residents have several ways to report incidents. They also have established hotlines for both staff and residents to use to report PREA incidents. The Auditor tried the phone number while on–site and it worked appropriately.

Facility Policy addresses this standard and provides for multiple internal ways a resident may report allegations of sexual abuse and sexual harassment, including how they can privately report sexual abuse and sexual harassment; retaliation for reporting; and staff neglect or violations of responsibilities that may have contributed to such. Residents may report allegations of sexual abuse or sexual harassment by telephone through the 24-hour hotline of an agency not a part of the facility as confirmed by resident interviews, posters, staff, MOU, and posted phone instructions. BNJJC staff interviews revealed residents may use the telephone, located on each unit, to privately report sexual abuse and sexual harassment. The telephone was tested during the comprehensive site review and was found to be in working order.

The residents also identified internal ways a resident may report such as completing a grievance form; talking to a trusted staff member; completing a Medical Request Form; or tell an outside person or family member. There are designated locked boxes and forms on the living units for depositing the written grievance forms. If a resident uses a grievance form to report allegations of sexual abuse or sexual harassment, they just need to place their name on the form, check the appropriate space and place it in the grievance box.

The resident receives a Safety Pamphlet and Resident Handbook which provides PREA related information, including how to report allegations of sexual abuse. Posters are located in the living units and other areas visible to residents, staff, contractors and visitors. Residents revealed they have contact with someone who does not work at the facility such as a family member or other person they could report abuse to if needed. Staff members receive information on how to report allegations of sexual abuse or sexual harassment through policies and procedures, training, and staff meetings.

Provision (b):
The agency 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 the agency 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.

Residents may use of the emergency telephone located on each unit. The resident may select the appropriate line and dial a number to reach a victim advocate at The Hotline for Children Abuse or the Rainbow House Advocacy Center to report an allegation of abuse and/or request advocacy services. Signs are posted explaining how to access non-emergency numbers for agencies, including the Police Division. The resident is also instructed on the signage to dial 911 for emergencies. BNJJC staff revealed staff could use the emergency phone to report allegations of abuse. Allegations of sexual abuse have not been reported during this audit period. The facility does not detain residents solely for civil immigration purposes.

Provision (c):
Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports.

BNJJC requires all staff to report immediately, in accordance with BNJJC Policy 17.11, any knowledge, suspicion, or information regarding an incident of offender sexual abuse or offender sexual harassment. All staff are required to report retaliation against offenders or staff who reported such an incident, and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

The staff interviews confirmed the methods available to residents for reporting allegations of sexual abuse and sexual harassment. Staff members are required to accept third-party reports and to document verbal reports. All residents interviewed revealed they are familiar with the provisions of the standard. The resident interviews demonstrated their familiarity with the various ways they may report either in person, in writing, by phone, completing a grievance or Medical Request Form, or through a third-party. The residents were aware third-party reports could be made and that reports can be made anonymously. Staff members interviewed was aware of their duty to receive and document third-party reports.

The facility shall provide residents with access to tools necessary to make a written report. Writing materials are readily available for residents to complete the accessible forms. Prior to the site visit pictures were sent to the Auditor showing the reporting forms such as Grievance forms and Medical

Request Forms and the accessibility of writing utensils. During the site visit and while on the site review, the Auditor observed the accessibility of writing utensils to the residents.

Provision (d):
The agency shall provide a method for staff to privately report sexual abuse and sexual harassment of residents.

The staff interviews revealed staff can privately report allegations of sexual abuse. The interviews collectively identified the following ways a report can be made privately: use of the telephone on the living units; use of telephone in an office; third-party reporting form online; report by email to administrative staff; and/or talk to supervisor in private.

All information concerning an event of offender sexual abuse or sexual harassment is to be treated as confidential. Apart from reporting to designated supervisors or officials, staff shall not reveal any information related to a sexual abuse/harassment report to anyone other to the extent necessary, as specified in BNJJC Policy 17.11, to make treatment, investigation, and other security and management decisions.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding resident reporting. The residents have multiple internal ways to privately report. Reports can be made verbally, in writing, anonymously, and from third parties. Verbal reports would be documented immediately. Residents have access to pens and pencils to write a grievance or complete a Medical Request Form. Staff can privately report sexual abuse and sexual harassment of residents.

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 ☐ NA

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 allegation 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.

Documents Reviewed:
Facility Policy 7.3, Juvenile Rights, Written Grievance Procedures for Residents
Facility Policy 7.3, PREA Policy-Reporting
Facility Policy 17.12, Investigations
Juvenile PREA Intake Orientation Acknowledgement
Detention Unit Rules and Expectations Compliance Agreement
Grievance Forms
Third Party Reporting Forms
Safety Pamphlet
Sample of Incident Report
Resident Handbook
Observed PREA Posters

Interviews:
Residents
Random Staff
PCM

Provision (a):
An agency shall be exempt from this standard if it does not have administrative procedures to address resident grievances regarding sexual abuse.

The Auditor confirmed BNJJC has administrative procedures to address resident grievances regarding sexual abuse as determined by the review of Policy 7.3 Juvenile Rights, no grievances have been filed related to sexual abuse and no evidence to the contrary. Although there is a facility grievance procedure available for the youth, PREA Policy page 9 indicates that PREA allegations are not officially accepted through this method. In the interviews with the Superintendent, it was stated that if a grievance or note from the grievance box indicates a PREA allegation being reported, the grievance is immediately treated as if it had just been reported verbally with proper steps and reporting conducted.

Provision (b):
(1) The agency shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse.
(2) The agency may apply otherwise-applicable time limits on any portion of a grievance that does not allege an incident of sexual abuse.
(3) The agency shall not require a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse.
(4) Nothing in this section shall restrict the agency's ability to defend against a lawsuit filed by a resident claiming the applicable statute of limitations has expired.

The facility Policy provide for the above provisions. Based on the review of the Resident Handbook, Administrative Review of Grievance form, resident interviews, and observations, the facility provides relevant information to the residents and has timelines in place to adhere to this provision of the standard.

Provision (c):
The agency shall ensure that—
(1) A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint, and
(2) Such grievance is not referred to a staff member who is the subject of the complaint.

According to the Policy, formal and informal staff interviews, and observations, residents are not required to give a grievance to a staff member and staff members are not permitted to place a grievance in the box for the resident. A locked grievance box is located on each housing unit.

Provision (d):
(1) The agency shall 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.
(2) Computation of the 90-day time period shall not include time consumed by residents in preparing any administrative appeal.
(3) The agency may claim an extension of time to respond, of up to 70 days, if the normal time period for response is insufficient to make an appropriate decision. The agency shall notify the resident in writing of any such extension and provide a date by which a decision will be made.
(4) 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, the resident may consider the absence of a response to be a denial at that level.

There were no grievances filed that alleged sexual abuse in the 12 months preceding the audit. Based on the review of the Policy, resident interviews and Pre-audit questionnaire and associated memos of non-occurrence by the Superintendent, evidence shows the facility follows this provision of the standard.

Provision (e):
(1) Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, shall be permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of residents.
(2) 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.
(3) If the resident declines to have the request processed on his or her behalf, the agency shall document the resident's decision.
(4) A parent or legal guardian of a juvenile shall be allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile. Such a grievance shall not be conditioned upon the juvenile agreeing to have the request filed on his or her behalf.

The Policy and the Third Party Reporting Form provide that third parties may file a grievance on behalf of residents and such action is not conditioned upon the resident agreeing to the filing of the grievance. There were no grievances alleging sexual abuse filed in the 12 months preceding the audit in which the resident declined third-party assistance. Based on the review of the Pre-audit questionnaire, and associated memos of non-occurrence, evidence shows the facility follows this provision of the standard.

Provision (f):
(1) The agency shall establish procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse.
(2) After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, the agency shall 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, shall provide an initial response within 48 hours, and shall issue a final agency decision within five calendar days. The initial response and final agency decision shall document the agency's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance.

The Policy provides for this provision of the standard. Once the grievance is received, it is dealt with through the appropriate administrative channels and Policy states that the resident will receive an initial response within 48 hours and a final agency decision within five calendar days.

Provision (g):
The agency may discipline a resident for filing a grievance related to alleged sexual abuse only where the agency demonstrates that the resident filed the grievance in bad faith.

The Policy requires the actions of this standard provision. During the past 12 months, there were no resident grievances alleging sexual abuse that resulted in disciplinary action by the agency against the resident for having filed the grievance in bad faith. Based on the review of the Policy, associated memos of non-occurrence, and posted information, evidence shows the facility follows this provision of the standard.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding exhaustion of administrative remedies. BNJJC has an administrative procedure for dealing with resident grievances regarding sexual abuse that is inclusive of all provisions required by the standard. The grievance procedure is contained in the Resident Handbook and explained to the residents.

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? ☒ Yes ☐ No

- 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.

Documents Reviewed:
Facility Policy 17.11, Reporting of PREA Violations
Mutual Agreement with Rape Crisis Center – Rainbow House
PREA Brochure (Safety Pamphlet)
PREA Notification/Acknowledgement Form
Resident Handbook
Posted Information

Interviews:
Residents
Superintendent
PREA Coordinator
Program Manager, Advocacy Agency

Provision (a):

The facility shall provide residents with access to outside victim advocates for emotional support services related to sexual abuse, 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, and, for persons detained solely for civil immigration purposes, immigrant services agencies. The facility shall enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible.

The facility currently has a letter/agreement with the Rape Crisis Center – Rainbow House, to provide supportive services to youth upon request. Posters containing the OHI hot-line number are prominently posted in the hallways and lobby area. Staff and youth interviews confirmed that staff provide youth with the limitations of confidentiality regarding mandatory reporting laws. Youth communications to these services are not monitored. Youth interviews confirmed that those who currently have attorneys can communicate with them confidentially. None reported being denied access to their attorneys. All youth reported that they have family visitation and that they have never been denied access to their families. All youth are allowed to make phone calls weekly to family members.

Provision (b):
The facility 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.

The Policy addresses confidentiality of the advocacy support services. The resident receives information regarding the limitations of confidentiality during the intake process. An acknowledgement statement specific to the review of the reporting and advocacy services contains information regarding the advocacy services to be provided by The Rainbow House. Samples of acknowledgement statements were reviewed.

Provision (c):
The agency shall 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. The agency shall maintain copies of agreements or documentation showing attempts to enter into such agreements.

The facility Policy states the facility has a MOU with the advocacy agency, available by telephone to the resident for access to outside confidential support services. The resident may use the phone, located on each living unit, and push the appropriate number to gain access and speak with a victim advocate. The agency is identified on the signage along with directions for reporting allegations or requesting advocacy services. The Superintendent and the APC confirmed the availability and accessibility of outside confidential support services to residents. The Program Manager of the advocacy agency stated that an advocate would go to the facility or the hospital upon request.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding resident access to outside confidential support services and legal representation.

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.

Documents Reviewed:
Facility Policy 17.11, Reporting of PREA Violations
Mutual Agreement with Rape Crisis Center – Rainbow House
PREA Brochure (Safety Pamphlet)
PREA Notification/Acknowledgement Form
Resident Handbook

Interviews:
Random Staff
Residents
PCM

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

The Policy addresses third-party reporting and interviews revealed random staff members are aware third-party reporting of sexual abuse and sexual harassment can be done and stated they will be accepted and reported. Staff members also stated they are to immediately document all verbal reports received. The interviews revealed they may report allegations privately through the use of the abuse reporting hotline or a third party reporting form.

All residents interviewed stated they knew someone who did not work at the facility they could report to regarding allegations of sexual abuse and that person could make a report for them. The interviews

with the residents revealed their knowledge of third-party reporting. The residents identified the methods within the facility in which they may make third party reports such as file an emergency grievance, report to staff or a family member, or utilize the abuse reporting hotline telephone.

Information regarding reporting is provided through observed postings located in various areas of the facility accessible to visitors, residents, staff, contractors and volunteers. The facility's website contains information regarding third-party reporting of allegations of sexual abuse. The Third Party Reporting Form is observed to be located on the website. Copies of the Third Party Reporting form are maintained in the lobby and the reporting information is provided to parents/guardians. There were no third- party reports received during this audit period.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor determined the facility is in compliance regarding third-party reporting. The facility provides various methods for third-party reports of sexual abuse or sexual harassment.

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 the 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? (N/A if the alleged victim is not under the guardianship of the child welfare system.) ☒ Yes ☐ No ☐ NA

- 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.

Documents Reviewed:
Facility Policy 17.11, Reporting of PREA Violations
Facility Policy 3.1Court Operating Rule 7- Personnel Management
Facility Policy2.7, Administration – Reporting of Allegations of Abuse or Neglect
Counselor's Case Notes
PREA Clinical Investigation Checklist

Interviews:
Random Staff
Contract Medical Staff
Nurse/Mental Health Staff Local Hospital
Superintendent/PCM

Provision (a) and (b):
The agency shall require all staff to report immediately and according to agency policy 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. (b): The agency shall also require all staff to comply with any applicable mandatory child abuse reporting laws.

The Policies collectively address provisions of the standard including providing all staff immediately report any knowledge, suspicion, information, or receipt of information regarding an incident or allegation of sexual abuse, sexual harassment or incidents of retaliation and according to mandatory reporting laws. PREA policy page 9 and Court Operating Rule 7 state that any person(s) providing services in the facility who receives information, regardless of its source, concerning staff sexual misconduct, youth sexual abuse, sexual harassment, or youth sexual misconduct, or who have reason to suspect, or who observe an incident, are required to immediately report the incident to the Shift Supervisor and Superintendent or Designee. Policy states that employees, volunteers, contractors and interns with Family Court Services are mandatory reporters for child abuse; and are obligated by law to abide by this policy (i.e., Reporting Alleged Abuse). The Agency's trained investigators conduct PREA investigations and allegations that are criminal in nature, are referred to the Kirksville Police Division. Allegations of sexual abuse are also reported to the child protective agency where the incident occurred.

Policy states that all information related to a victim of staff sexual misconduct or youth sexual abuse shall be considered confidential and shall only be released to those who need this information to perform their duties. All staff understands that they are mandatory reporters. Medical and mental health staff report that they inform youth of their duty to report and the limitations of confidentiality at the initiation of services. All staff is mandated child abuse reporters and receives appropriate training. Staff interviews confirmed that medical staff is mandated child abuse reporters and that they inform youth of their duty to report and the limitations of confidentiality.

Provision (c):
Apart from reporting to designated supervisors or officials and designated State or local services agencies, staff shall be 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.

Facility Policy 2.7 supports that after allegations have been appropriately reported, staff will not be permitted to give out any other information relating to what was reported except when necessary to obtain treatment for the resident, aid in the investigation, or help retain the security of the facility. Staff is expected to continue to abide by the confidentiality requirements of the facility. Interviews with staff indicated their knowledge of the prohibition of 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. Based on the review of documentation and interviews with staff, it is evident the facility follows this provision of the standard.

Provision (d):
(1) Medical and mental health practitioners shall be 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. (2) Such practitioners shall be required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality.

The medical and mental health staff interviewed stated residents are informed at the initiation of services of the limitations of confidentiality and the duty of the staff members to report. The clinical staff interviewed revealed they are mandated reporters. They also indicated informed consent would be documented for a resident 18 years old and over regarding reporting allegations of sexual abuse that did not occur in an institutional setting.

Provision (e):
The facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators.

The Policies collectively provide for all allegations to be reported to the facility-based investigators, including third-party and anonymous reports as also verified by staff interviews.

Conclusion:
The interviews with random staff, mental health and medical staff and Superintendent revealed their awareness of the requirements regarding the reporting duties. All staff interviewed acknowledged they are mandated reporters and a written report must immediately follow reported allegations or incidents. The random staff interviewed provided the reporting requirements and that staff is expected to document receipt of verbal reports immediately. The facility staff members are also required by the Policy to report allegations that were made anonymously or by a third-party. During this audit period, there were no allegations of sexual abuse.

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.

Document Reviewed:
Facility Policy 17.11, Reporting of PREA Violations
Facility Policy 3.1Court Operating Rule 7- Personnel Management
Facility Policy 2.7, Administration – Reporting of Allegations of Abuse or Neglect
Counselor's Case Notes

Interviews:
Superintendent/PCM
Random Staff
Random Residents

Provision (a) §115.362
When an agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the resident.

Facility Policy requires staff to protect the residents through implementing protective measures. Administration of the Vulnerability Assessment provides information that assists and guide staff in keeping residents safe through housing and program assignments. The interviews of the random staff and the Superintendent revealed protective measures include but are not limited to alerting supervisors and management staff and separating the residents including moving to a different housing unit. The Superintendent and the random staff indicated the expectation is that any action to protect a resident would be taken immediately.

The interviews with the residents revealed during the intake process, how they feel about their safety is part of the inquiries by staff in completing paperwork. A review of a sample of Vulnerability Assessments supports the information provided by residents. The Superintendent reported during the past 12 months, no residents were identified as being subject to substantial risk of imminent sexual abuse. Although there were no instances during the previous 12 months where a youth was subject to a substantial risk of sexual abuse, during interviews all security and specialized staff clearly stated their understanding of the importance and duty to protect youth from harm. Furthermore, PREA policy page 9 requires that if staff has a reason to believe that staff sexual misconduct or youth sexual abuse has occurred, the employee shall take reasonable and appropriate measures to assure victim safety. Staff reports that they are to separate the youth and notify the Superintendent. The Checklists regarding the investigations of allegations serves to assist the investigator in ensuring the required protocols are followed.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard and the provisions regarding agency protection duties.

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.

Documents Reviewed:

Facility Policy 17.11, Reporting of PREA Violations
Facility Policy 2.7, Administration - Reporting Obligation of Allegations of Abuse or Neglect

PREA Incident Report Log

Interviews:
Superintendent/PCM

Provisions (a), (b), (c), and (d):
Upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred and shall also notify the appropriate investigative agency. (b) Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation. (c) The agency shall document that it has provided such notification. (d) The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards.

BNJJC has not had any incidents reported to them or that they have had to report during the auditing period. They do have a policy that cover their responsibilities it if were to occur. PREA policy 17.11 page 4 states that allegations of sexual abuse reported to have occurred at a prior facility or any institution shall require that the Superintendent receiving the report notify the Superintendent where the alleged incident occurred. If there is no evidence in the OHI database that a report has been made previously, a report shall be made per agency policy. The Superintendent stated in her interview that it is expected that such a report be made immediately upon learning of the allegation. There were no such reports or allegations made during the previous 12 months. While there has not been an allegation of sexual abuse made by another facility in the previous 12 months, program policy requires prompt notification, documentation and follow-up with the particular reporting facility. Also, agency policy requires mandated reporters to report such an allegation to OHI.

Conclusion:
Based upon the information received and interviews, the Auditor has determined the facility is compliant with this standard regarding reporting to other confinement facilities.

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.

Documents Reviewed:
Facility Policy 17.11, Reporting of PREA Violations
Facility Policy 2.7, Administration - Reporting Obligation of Allegations of Abuse or Neglect
Facility Manual First Responder and Coordinated Response

Interviews:
Random Staff
Non-Security Staff First Responder

Provision (a):
Upon learning of an allegation that a resident was sexually abused, the first 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.

Facility Policy provides that upon learning of an allegation that a resident was sexually abused, the first security-level staff member to respond to the report shall be required to:
(a.) Separate the alleged victim and abuser;
(b.) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;
(c.) 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.

The interviews with staff confirmed awareness of first responder duties and the training they had been provided. There were no allegations that a resident was sexually abused in the last 12 months.

Provision (b):
If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff.

An Assistant Administrator interviewed as non-security staff who may act as a first responder was familiar with the duties in that role. He indicated he would alert the supervisor, separate the victim and perpetrator, and request the victim and perpetrator do not take any actions that could destroy physical evidence. He further stated he would go with the victim to the hospital.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding staff first responder duties.

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.

Documents Reviewed:
Facility Policy 17.11, Reporting of PREA Violations
Facility Policy 2.7, Administration - Reporting Obligation of Allegations of Abuse or Neglect
Facility Manual First Responder and Coordinated Response
Coordinated Response Flow Chart
Criminal Investigation Checklist
Administrative Investigation Checklist
Interviews:
Superintendent
Random Staff

Provision (a): §115.365
The facility shall develop 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.

The facility has developed a Coordinated Response Flow Chart which is aligned with the detailed information in the policy regarding the response to an allegation or incident of sexual abuse. The Plan outlines the actions of the identified staff members such as the first responder; supervisors; medical; mental health; and management. The flow chart maps out the steps to take and staff responsibilities. The Checklists assist staff in confirming protocols are followed, including proper and timely notifications.

The random staff interviewed was familiar with the roles regarding the response to an allegation of sexual abuse. The Superintendent discussed the coordinated actions in response to an incident of sexual abuse which was parallel to Policy and the flow chart. Staff members are directed to follow the steps outlined and to utilize the Checklist in addressing the situation.

The facility has a written, site-specific, detailed Coordinated Response Plan for PREA Related Incidents that reflects the requirements of policy. This Auditor reviewed the site-specific Coordinated Response Plan. All staff could articulate that the plan could be accessed in the control room. The plan was site-specific

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility complies with the provisions of the standard regarding a coordinated response to an incident of sexual abuse. No allegations of sexual abuse have been reported during this audit period.

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.

Provision (a):
This standard is N/A. There are no agreements of the type defined in the standard in place or contemplated. There is no policy that would prohibit the BNJJC from removing alleged staff sexual abusers from contact with any resident pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.

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 for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, 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? ☒ 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.

Documentation Reviewed:
Facility Policy 17.11, Reporting
Facility Policy 3.2, Court Operating Rule 7
Retaliation Status Check Checklist
Retaliation Monitoring Checklist

Interviews:
Retaliation Monitor
Superintendent/PCM

Provision (a):
The agency shall establish 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 and shall designate which staff members or departments are charged with monitoring retaliation.

The BNJJC Policy states the facility shall protect all residents and staff from retaliation who report sexual abuse, sexual harassment or cooperate with sexual abuse or sexual harassment investigations. The Superintendent is responsible for monitoring retaliation. Periodic checks are included. Monitoring shall consist of a review of the following: (a.) the youth's disciplinary reports, (b.) Housing and room assignment, (c.) Program changes, (d.) Staff performance reviews and, (e.) Staff assignments and duties. Finally, the policy states that monitoring terminates once the allegation has been labeled unfounded by the investigating entity. The interview with the Superintendent confirmed she serves as

the retaliation monitor. Although there have been no allegations of sexual abuse or sexual harassment and the need for retaliation monitoring, the APC revealed his understanding of the role of the retaliation monitor.

Provision (b):
The agency shall 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.

The Policy identifies measures to protect staff and residents including the following:
(a.) Initiating housing changes or transfers for resident victims or abusers;
(b.) Removing alleged staff or resident abusers from contact with victims; and
(c.) Providing emotional support services.

The interview confirmed the facility would protect residents and staff from retaliation for sexual abuse and sexual harassment allegations. Protective measures would include housing changes, transfers, removing alleged abusers, and emotional support services. The Superintendent identified protective measures that are aligned with the Policy and standard, including separating the alleged abuser from the alleged victim. The Superintendent was knowledgeable on what to look for and what to do with respect to retaliation against, or by, youth and/or staff. This includes periodic status checks. There were no instances of actual or threatened retaliation during the previous 12 months.

Provision (c):
For at least 90 days following a report of sexual abuse, the agency shall monitor the conduct or treatment of residents or staff who reported the sexual abuse and 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, and shall act promptly to remedy any such retaliation. Items the agency should monitor include any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need.

The Policy requires the monitoring of items identified in this provision of the standard. Superintendent explained during the interview how she would discharges those duties, including monitoring the items identified in the standard and whether a resident filed a grievance alleging sexual abuse or sexual harassment. Retaliation monitoring would occur for 90 days to see if there are any changes that may suggest possible retaliation by residents or staff, and shall act promptly to remedy any such retaliation, according to Policy. The monitoring will continue beyond 90 days, if the initial monitoring indicates a continuing need. There have been no incidents of retaliation during the 12 months preceding the audit.

Provision (d):
In the case of residents, such monitoring shall also include periodic status checks.

The Superintendent indicated status checks would be initiated with staff and residents. The Policy states periodic status checks will occur. The Retaliation Status Checklist would be used to document the status checks as well as the Retaliation Monitoring Checklist to document the ongoing motoring and use of the Retaliation Status Checklist.

Provision (e):
If any other individual who cooperates with an investigation expresses a fear of retaliation, the facility shall take appropriate measures to protect that individual against retaliation.

The Policy states if any other individual who cooperates with an investigation expresses the occurrence retaliation from another resident or staff member, BNJJC shall take appropriate measures to protect that individual against retaliation.

Provision (f):
An agency's obligation to monitor shall terminate if the agency determines that the allegation is unfounded.

The BNJJC Policy states the facility's obligation to monitor shall terminate if it is determined that the allegation is unfounded.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding agency protection against retaliation.

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.

Documentation Reviewed:
Facility Policy 17.11, Reporting
Facility Policy 3.2, Court Operating Rule 7
Retaliation Status Check Checklist
Retaliation Monitoring Checklist

Interviews:
Retaliation Monitor
Superintendent/PCM

Provision (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?

This is N/A. The facility does not utilize any form of segregated housing. Facility Policy 9.6 states whenever room restriction or confinement is imposed as a consequence for a behavior of concern, the juvenile shall not be restricted or confined in excess of 24 hours unless the Superintendent of Detention or Designee has reviewed the juvenile's status. A review shall occur at least every 24 hours to determine the continued need for room restriction or confinement.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding agency protection against retaliation.

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 entity 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.

Documents Reviewed:
Facility Policy 17.12 - Investigations
Facility Policy 2.7, Bruce Normile Juvenile Justice Center Standard of Operations Procedures-Administration
Out of Home Investigative (OHI) Protocol and Procedures
Rainbow House Regional Child Advocacy Center Sexual Assault Protocol for Adolescent Victims Memorandum of Agreement email

Interviews:
OHI Manager
Superintendent/PCM
Random Staff

Provision (a):
When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports.

The facility does not conduct criminal investigations according to Court Operating Rule 7 Section B and Agency PREA Policies Section 2 and 3. Referrals are made to OHI, who will conduct administrative investigations and the Kirksville Police Department will conduct criminal investigations. The Policy states that the facility appointing authority (usually the Superintendent) shall ensure cooperation and coordination with all investigating agencies/persons, and that the facility shall share all pertinent documentation, records, and available information with the agency. There were no PREA-related allegations made during the previous twelve months.

Provision (b):
Where sexual abuse is alleged, the agency shall use investigators who have received special training in sexual abuse investigations involving juvenile victims pursuant to § 115.334.

The facility does not conduct criminal investigations according to Court Operating Rule 7 Section B and Agency PREA Policies Section 2 and 3. Referrals are made to OHI, who will conduct administrative investigations and the Kirksville Police Department will conduct criminal investigations. The OHI Manager stated that all investigators have received additional training in conducting investigations

Provision (c):
Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator.

Per Policy 2.7, the Agency requires the office of OHI to conduct investigations. The OHI Manager stated that all investigators have received additional training in conducting investigations as confirmed by a review of training certificates, training log, and training curriculum. The coarse lesson topics included how to gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; investigators are required to interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator.

Provision (d):
The agency shall not terminate an investigation solely because the source of the allegation recants the allegation.

Policy 2.7 provides that an investigation will not be terminated solely because the source recants the allegation. The interviews confirmed what the practice will be in accordance with the Policy and standard.

Provision (e):
When the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.

Investigations that are criminal in nature are investigated by the Kirksville Police Department as determined by staff interviews, MOU, Letter from Police Chief and Policy 2.7 supports this provision.

Provision (f):
The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. No agency shall require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation.

Policy 3.1 & 2.7 states the credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and not be determined by the person's status as a resident or staff. Additionally, no resident who alleges sexual abuse will be subjected to a polygraph examination or other truth telling device as a condition for proceeding with the investigation of the allegation. The interviews with the facility-based investigators support the Policy.

Provision (g):
Administrative investigations:
(1) Shall include an effort to determine whether staff actions or failures to act contributed to the abuse;
(2) Shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.

The Policies, interviews and training documentation are inclusive of this provision of the standard. The Out of Home Investigators (OHI) has been identified as administrative investigators. The investigators have received the regular PREA training as evident through documentation. The BMJJC staff has received training in first responder duties and understanding the agency's protocol for obtaining usable physical evidence if a resident alleges sexual abuse, as confirmed by a review of training log, and curriculum.

Provision (h):
Criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible.

Interviews with the facility Superintendent/PCM and Kirksville Police Representatives, as well as a review of agency policy indicate compliance of this provision of the standard. Although no training documentation was available for review at the time of the on-site audit, the representative of the Kirksville Police Department stated that appropriate training has been received by the Division's investigators and their experience to conduct a professional investigation. No criminal investigations have been conducted at the facility during this audit period.

Provision (i):
Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution.

The Policy provides that all criminal investigations are referred to and conducted by the Kirksville Police Department. The Police Division is responsible for referring for prosecution based on the outcome of the investigation. Policy 2.7 is inclusive of this provision of the standard.

Provision (j):
The agency shall retain all written reports referenced in paragraphs (g) and (h) of this section 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.

Policy 3.1 states all reports shall be retained while the abuser is incarcerated or employed by the agency, plus five years, unless applicable law requires a shorter period of retention.

Provision (k):
The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation.

Policy 3.1 provides and interviews support that the departure of the alleged abuser or victim from employment or control of BNJJC shall not provide a basis for terminating an investigation, which was also supported by interviews.

Provision (l):
When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.

BNJJC 3.1 states staff shall cooperate with any outside investigators and shall remain informed about the progress of the investigation. According to the Superintendent, the case number is provided when an outside investigation is conducted so that follow-up can occur as needed. There have not been any allegations of sexual abuse during this audit period.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding criminal and administrative agency investigations. All allegations of sexual abuse and sexual harassment are referred to a law enforcement agency. It shall be the responsibility of the law enforcement agency investigator to gather and preserve direct and circumstantial evidence including any available physical and DNA evidence and any available electronic monitoring data; to interview alleged victims, suspected perpetrators, and witnesses; and to review prior complaints and reports of sexual abuse involving the suspected perpetrator.

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.

Documents Reviewed:
Facility Policy 17.12 Investigation

Facility Policy 2.7 Administration – Reporting of Abuse or Neglect

Interviews:
OHI Manager
Superintendent/PCM

Provision (i): §115.272
The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

Neither the agency, nor the facility, conducts criminal investigations of allegations of sexual abuse or sexual harassment. OHI conducts administrative investigations when deemed appropriate. Once a substantiated finding is made by either the OHI or law enforcement, the agency may take disciplinary action. The Superintendent reported that in practice the standard shall impose no standard higher than the preponderance of evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. Agency Policy states the facility shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. A review of policy and interviews with the OHI Manager and PREA Compliance Manager, were aligned with the Policy.

Conclusion:
Based upon the review and analysis of the available evidence and the interviews, the Auditor has determined the facility is compliant with this standard regarding evidentiary standard for administrative investigations.

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 an agency 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.

Documents Reviewed:
Facility Policy 17.12, Investigations – Reporting to Youth
Residents Notification of Findings form

Interviews:
OHI Manager
Superintendent
PREA Coordinator

Provision (a):
Following an investigation into a resident's allegation of sexual abuse suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.

Facility Policy addresses the resident being informed by staff when the investigation is completed, informed of the outcome of the investigation, and the documentation of the notification. The Superintendent and the APC will remain abreast of an investigation conducted by any of the investigative entities by serving as the primary contact person(s), as determined by the interviews. The BNJJC Policy provides that any resident who makes an allegation of sexual abuse shall be informed verbally by the Superintendent and APC in writing following an investigation, as to whether or not the allegation was substantiated, unsubstantiated, or unfounded.

PREA Policy 17.12 page 10 addresses the requirements of this standard. Following an investigation into a youth's allegation of sexual abuse and receipt of the investigating agency's finding or findings, the Superintendent shall inform the youth the determined outcome. Following a youth's allegation that an employee has committed sexual abuse against the youth, the Superintendent shall inform the youth when: (a.) The employee is no longer employed at the facility; (b.) The employee is no longer posted on the youth's unit; (c.) The facility has learned that the employee has been criminally charged as a result of the allegation; or (d.) The facility has learned that the employee has been convicted of charges related to the allegation.

Provision (b):
If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident.

The BNJJC Policy states the facility shall request all relevant information from the investigating agency in order to inform the resident of the outcome of the investigation.

Provision (c):
Following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency shall subsequently inform the resident (unless the agency 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.

The Policy requires that following a resident's allegation that a staff member committed sexual abuse against the resident, the resident will be informed of the following, unless it has been determined that the allegation is unfounded, whenever:
(a.) The staff member is no longer assigned within the resident's housing unit;
(b.) The staff member is no longer employed at the facility;
(c.) The staff member has been indicted on a charge related to sexual abuse within BNJJC; or
(d.) The staff member has been convicted on a charge related to sexual abuse within the facility.

Provision (d):
Following a resident's allegation that he or she has been sexually abused by another resident, the agency shall 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.

The BNJJC Policy provides that following a resident's allegation that he has been sexually abused by another resident; the alleged victim shall be subsequently informed whenever:
(a.) The alleged abuser is criminally charged related to the sexual abuse; or
(b.) The alleged abuser is adjudicated on a charge related to sexual abuse.

Provision (e):
All such notifications or attempted notifications shall be documented.

The Policy provides that all such notifications or attempted notifications be documented. The BNJJC Resident Notification of Findings form has been created and would serve to notify the resident, in writing, regarding the provisions of this standard.

Provision (f):
An agency's obligation to report under this standard shall terminate if the resident is released from the agency's custody.

The Policy provides the facility's obligation to report under this standard shall terminate if the resident is released from the facility's custody.

Conclusion:
The interviews with the identified staff confirm the Policy requirements and their knowledge of the process of reporting to a resident regarding the outcomes of an allegation of sexual abuse. Based on the review and analysis of the available documentation and interviews, the Auditor has determined the facility is compliant with this standard regarding reporting to residents.

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.

Documents Reviewed:
Facility Policy 17.13, Discipline

Interview:
Superintendent
Random Staff
Random Residents

Provision (a):
Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

The Court Operating Rule 7 states that staff who violate agency sexual abuse or sexual harassment policies are subject to disciplinary action. Disciplinary actions include a variety of sanctions, including termination. The sanction for a substantiated finding of sexual abuse is presumed to be termination in that such criminal charges usually result in incarceration. Any disciplinary action taken in a specific case depends on a number of variables and should be commensurate to the nature and circumstances of the acts committed, among other considerations. Agency policy requires all allegations of sexual abuse be reported to the Kirksville Police Department, regardless of whether the staff resigns or is terminated. This was confirmed in the interview with the Superintendent. The Agency Policy provides that staff be subject to disciplinary sanctions up to and including termination for violating facility sexual abuse or sexual harassment policies. The interview with the Superintendent confirmed the Policy.

Provision (b):
Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse.

The Policy states that termination shall be the presumptive disciplinary sanction for staff who has engaged in sexual abuse with a resident as confirmed by the Superintendent.

Provision (c):
Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than engaging in sexual abuse) shall be 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.

Policy provides that disciplinary sanctions for violations of BNJJC policies relating to sexual abuse or sexual harassment (other than engaging in sexual abuse) shall be 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. Additionally, the Policy states all employee discipline and termination are governed solely by At Will employee law.

Provision (d):
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, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

BNJJC Policy states all terminations for violations of the facility's sexual abuse or sexual harassment policies, or staff resignations related to violations of this policy, shall be reported to law enforcement, unless the activity is clearly not criminal. In addition, it shall be reported to relevant licensing bodies.

Conclusion:
Based upon the review of Policy and interview, the Auditor has determined the facility is compliant with this standard regarding disciplinary sanctions for staff. BNJJC Policy 13.8 covers this standard. They had no incidents to report.

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.

Documents Reviewed:
Facility Policy 17.13, Discipline

Interview:
Superintendent
Random Staff
Random Residents
Contractors (2)

Provision (a):
Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.

PREA policy page 11 states that the Superintendent, or designee, is required to curtail, postpone or discontinue the services of a contractor, intern, volunteer or similar individual or volunteer organization, when substantial reasons for doing so exist, such as unlawful conduct or breach of facility rules, and regulations or engaging in activities that threaten the safety, order or security of the facility. The Superintendent reported that in the event the contractor or volunteer held a professional license issued by the state, the applicable licensing authority would be notified. Training records revealed the facility provides volunteers and contractors a clear understanding that sexual misconduct with a resident is strictly prohibited. During this audit period, there have been no allegations of sexual abuse or sexual harassment regarding a contractor or volunteer.

Provision (b):
The facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

The Policy states the Superintendent will take appropriate remedial measures, and consider whether to prohibit further contact with residents in the case of any other violation of the sexual abuse and sexual harassment policies by a contractor or volunteer.

Conclusion:
Based upon the review and analysis of the available documentation, the Auditor has determined the facility is in compliant with this standard regarding corrective action for contractors and volunteers.

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)

- 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.

Documents Reviewed:
Facility Policy 17.13, Discipline

Interview:
Superintendent
Random Staff
Random Residents
Medical Providers

Provision (a):
A resident may be 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 or following a criminal finding of guilt for resident-on-resident sexual abuse.

The Policy 17.13, Discipline addresses an administrative process for dealing with rule violations and references the policy that deals with discipline. Sanctions are directly related to the seriousness of the negative behavior. The interview with the Superintendent revealed the process regarding allegations of resident-on-resident abuse which can include the resident being removed from the facility and placed in the detention center during the investigation by law enforcement.

PREA policy states that youth found to have sexually harmed others shall be offered therapy counseling or other interventions designed to address and correct the underlining reasons for their conduct. Youth consequences shall commensurate with the nature and circumstances of the sexual abuse or harassment committed, the youth's disciplinary history, and consequences imposed for comparable offenses committed by other youth with similar history. The facility takes into consideration whether a youth's mental disabilities or mental illness contributed to the behavior when determining what disciplinary sanctions, if any, will be imposed. The Superintendent also clarified that the facility does not make any determination regarding whether a particular activity constitutes sexual abuse. This determination is made by a trained OHI investigator, court system, and/or Law Enforcement.

Provision (b):
Any disciplinary sanctions shall be 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. In the event a disciplinary sanction results in the isolation of a resident, agencies shall not deny the resident daily large-muscle exercise or access to any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible.

BNJJC Policy provides that disciplinary sanctions are 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. In the extreme event a disciplinary sanction results in the isolation of a resident, BNJJC shall not deny the resident daily large-muscle exercise or access to any legally required educational programming or special education services. Policy further provides for daily visits by mental health and medical personnel. Residents shall also

have access to other programs and work opportunities to the extent possible and receive daily visits from medical and mental health staff, in accordance with Policy 5.01-1.

Provision (c):
The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.

The BNJJC Policy provides that the disciplinary process considers whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. This was confirmed by the interview with the Superintendent.

Provision (d):
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. The agency may require participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, but not as a condition to access to general programming or education.

BNJJC Policy provides the facility considers whether to offer the offending resident therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse participation. The facility may require participation in such interventions as a condition of access to privileges, but not as a condition to access to general programming or education.

Provision (e):
The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

BNJJC Policy provides the facility may discipline a resident for sexual contact with staff only upon finding that the staff member did not consent to such contact.

Provision (f):
For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.

The BNJJC Policy states a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.

Provision (g):
An agency may, in its discretion, prohibit all sexual activity between residents and may discipline residents for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

The Policy prohibits any sexual conduct between residents. All such conduct is subject to disciplinary action. Court processes occur after determination the sexual activity was coerced.

Conclusion:
There have been no residents placed in isolation as a disciplinary sanction for sexual abuse in the past 12 months. Additionally, there have been no administrative or criminal findings of resident-on-resident sexual abuse in the past 12 months. Based upon the review and analysis of the available documentation, the Auditor determined the facility is compliant with this standard regarding interventions and disciplinary sanctions for residents.

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.

Documents Reviewed:
Facility Policy 17.14, Medical and Mental Health Care

Interview:
Superintendent
Random Staff
Random Residents
Medical Providers

Provision (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?

PREA Policy 17.13 states that if the screening for abusiveness and victimization indicates that a youth has experienced prior victimization, whether it occurred in an institutional setting or in the community, the intake staff shall offer the youth a follow-up meeting with a facility contracted Mental Health provider.

Provision (b):
If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, 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?

PREA Policy 17.13 states that if the screening for abusiveness and victimization indicates that a youth has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, the intake staff shall offer the youth a follow-up meeting with a facility contracted Mental Health provider.

Provision (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?

PREA Policy 17.13 states that if the screening for abusiveness and victimization indicates that a youth has experienced prior victimization or has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, the intake staff shall offer the youth a follow-up meeting with a facility contracted Mental Health provider. The follow-up shall be completed within 14 days. All confidential data and files are labeled on a "need to know" basis. Superintendent and medical staff interviews verified the procedures.

Provision (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?

PREA Policy 17.13 states that 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. Interviews with medical staff confirmed that services would be provided, if requested by a youth.

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.

Documents Reviewed:
Facility Policy 17.14, Medical and Mental Health Care

Interview:
Superintendent
Random Staff
Random Residents
Medical Providers
Informed Consent Form

Provision (a) and (b):
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, staff shall ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. (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, staff shall ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening.

The Policy 17.14, Medical and Mental Health Care provides that a resident who indicates during initial screening that they were a victim or perpetrator of sexual abuse shall be offered a follow-up visit with medical or mental health staff within 14 days of the intake screening. Any youth alleging victimization are transported to Northeast Regional Medical Center where SANE services are available. Acute trauma care shall be provided by the SANE program including but not limited to, treatment of injuries, HIV/AIDS education, timely access to emergency contraception, prophylaxis and testing for Sexually Transmitted Diseases. The policy states that victims shall be provided trauma assessment, crisis intervention, safety planning and address treatment needs. The Mental Health Specialist shall see the youth victim, as soon as possible for assessment and crisis intervention, as appropriate. Based on the results of the trauma assessment, the Mental Health Specialist shall develop a short-term trauma plan (i.e., psychiatric care, medication, mental health counseling, etc.) and an on-going counseling plan as needed. Youth are informed during their intake orientation that all such services will be provided without financial costs (also written in the PREA information the youth receive). Medical staff and the Superintendent staff verified the procedures.

A review of documentation demonstrates residents are offered follow-up meetings in a timely manner, prior to the 14 days. This information was also confirmed through the interview with the PREA Compliance Manager, Medical providers and SANE/SAFE representatives.

Provision (c):
Any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law.

The Policy supports that any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law. The Auditor observed the resident files maintained in a secure manner. The files are secured in a locked cabinet behind a locked door, when the office is unoccupied. The files have a list of individuals that have access to them.

Provision (d):
Medical and mental health practitioners shall 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.

The Policy provides that medical and mental health practitioners shall 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. The facility has created the Informed Consent form to document this type of situation.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding medical and mental health screenings; and history of sexual abuse.

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.) ☒ 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.) ☒ 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.

Documents Reviewed:
Facility Policy 17.14, Medical and Mental Health Care
Informed Consent Form
Vulnerability Assessment: Risk of Victimization and/or Sexual Aggressiveness

Interviews:
Medical Staff
Mental Health Staff
Superintendent

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

The Policy requires that a medical and mental health evaluation and treatment be offered to resident victims of sexual abuse. According to the interviews, medical and mental health staff members are aware of the Policy mandates. The Policy and interviews support medical and mental health evaluations and treatment will be offered to all residents who have been victimized by sexual abuse. Interviews with the clinical staff and observations confirmed on-going medical and mental health care will be provided as appropriate, including assessments and therapy.

Agency Policy Court Operating Rule 7 states that the Mental Health Specialist shall see the youth victim as soon as possible for assessment and crisis intervention, as appropriate. Based on the results of the trauma assessment, the Mental Health Specialist shall develop a short-term trauma plan (i.e., psychiatric care, medication, mental health counseling, etc.) and an ongoing counseling plan as needed. Testing for Sexually Transmitted Diseases is provided, as medically appropriate. Youth are informed during their intake orientation that all such services will be provided without financial costs (also written in the PREA information each youth receive). Treatment can be provided to youth-on-youth abusers. Medical and Mental Health staff and the Superintendent verified the policy and procedures.

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

Interviews with the clinical staff and observations confirmed on-going medical and mental health care will be provided as appropriate and will include but not limited to additional testing and medical services; medication management, if prescribed; individual counseling; trauma group; and referrals as needed. The Policy states that follow-up services will be provided.

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

Facility Policy, staff interviews and observations revealed medical and mental health services are consistent with the community level of care.

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

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

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

The Policy and interviews ensure that victims of sexual abuse will be provided tests for sexually transmitted infections as medically appropriate. Testing would be done at Wood County Hospital and follow-up services may be done at the facility, as needed.

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

All treatment services will be provided at no cost to the victim, according to Policy and staff interviews.

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

Facility Policy provides for attempts to be made for a mental health practitioner to conduct a mental health evaluation within 60 days on all known resident-on-resident abusers and offer appropriate treatment by mental health staff. Services will include but not be limited to individual, group and family counseling. Additionally, an evaluation or reassessment will be administered utilizing the Vulnerability Assessment. The Counselor's interview supported the Policy.

Conclusion:
Based upon the review and analysis of the documentation, the Auditor has determined the facility is compliant with this standard regarding ongoing medical and mental health care for sexual abuse victims and abusers.

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.

Documents Reviewed:
Facility Policy 17.12 Investigations
Critical Incident Review Forms

Interviews:
Superintendent
Incident Review Team Member

Provision (a):
The facility shall 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.

Facility Policy 17.12 Investigations requires the facility to 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 deemed to be unfounded. The Superintendent is familiar with the Policy requirements. The Superintendent shall prepare a report of the findings to include recommendations for improvement. The report shall be submitted to the Court Services Administrator. The Superintendent may implement the recommendations for improvement or shall document the reasons for not doing so. In that there were no substantiated or unsubstantiated findings that required a review, there were none completed in the previous 12 months.

Provision (b):
Such review shall ordinarily occur within 30 days of the conclusion of the investigation.

There is a Critical Incident Review Form that would be completed within 30 days of the outcome of an Administrative or Criminal Investigation. The review process shall consider whether: (a.) Changes in the policy or practice are needed; (b.) Whether race, ethnicity, sexual orientation, gender identity, gang affiliation or youth culture in the facility played a role; (c.) Physical barriers in the facility; (d.) Staffing levels, and (e.) Video monitoring needs. The Superintendent shall invite the following persons to participate in the review: (a.) Chief Juvenile Officer; (b.) Facility Supervisors; Mental Health; and (d.) Medical. The Policy requires that the reviews occur within 30 days of the conclusion of the investigation. Although there has not been an allegation of sexual abuse, the APC and Superintendent confirmed incident reviews would occur within 30 days of the conclusion of an investigation in accordance with facility Policy and the standard.

Provision (c):
The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners.

The Policy identifies the incident review team members as administrators with input from line supervisors, investigators, medical staff, and Counselors. The investigators from the Kirksville Police Department would be invited to the meeting, according to the Policy. The interview with the Superintendent confirmed the Policy requirements.

Provision (d):
The review team shall: (1) Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse; (2) Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or, gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; (3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;

(4) Assess the adequacy of staffing levels in that area during different shifts; (5) Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and
(6) Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submit such report to the facility head and PREA compliance manager.

The Policy outlines the requirements of the standard for the areas to be assessed by the incident review team. The interview with the Superintendent, review of Policy and documentation method confirmed the incident review team is charged with considering the factors identified in this standard provision regarding the results of the investigation, including: considering the make-up and vulnerability of the population such as gang affiliation; whether the resident identifies as gay, bisexual, transgender, or intersex; other group dynamics; assessment of the area relative to the allegations; and adequacy of staffing.

The Policy requires the meeting to be documented, including recommendations and the document provided to the Superintendent. The interview with the PCM and Incident Review Team Member confirmed the facility would prepare a report of its findings and any recommendations for improvement when conducting a sexual abuse incident review. They confirmed the team would consider all factors required by the standard. A sexual abuse incident review has not been conducted during this audit period.

Provision (e):
The facility shall implement the recommendations for improvement, or shall document its reasons for not doing so.

The Policy states the administration shall implement the recommendations for improvement, or shall document its reasons for not doing so. The Superintendent is familiar with this Policy requirement. The form, Alleged Sexual Abuse & Sexual Assault Post-Incident Review, has been developed for documenting the incident review team meeting and it allows for documentation of the considerations of the standard. Additionally, the form provides for recommendations for improvement by the team members. There were no allegations of sexual abuse in the past 12 months.

Conclusion:
Based upon the review and analysis of the available documentation, the Auditor has determined the facility is compliant with this standard regarding sexual abuse incident reviews.

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.

Documents Reviewed:
Missouri Department of Social Services Data Collection Form
Critical Incident Review Form
PREA Data (Annual Report)

Interviews:
Agency PREA Coordinator
Superintendent

Provisions (a) & (c):
The agency shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. 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.

The Policy requires the use of a standardized instrument with definitions to collect accurate, uniform data for every allegation of sexual abuse. A review of the PREA Data document demonstrates that it includes data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the U. S. Department of Justice. The agency utilizes a survey for collecting data by the State of Missouri regarding sexual contact prevention.

Provision (b):
The agency shall aggregate the incident-based sexual abuse data at least annually.

The agency collects, aggregates, and maintains the data, as required by the standard. The data instrument collects the data necessary to answer all questions from the USDOJ Survey of Sexual Violence. This procedure was verified by the Detention Liaison to the Statewide Detention PREA Coordinator. BNJJC Procedures dictates that any incident report that alleges staff sexual misconduct, juvenile sexual misconduct or youth sexual abuse in Court Services facilities shall be collected by the Superintendent, who is also the Agency PREA Coordinator. The Superintendent shall be responsible for compiling records and annually reporting statistical data to the State of Missouri who then compiles all statewide data and submits to Federal Bureau of Justice as required by the Department of Justice. The Policy and review of the annual report and data gathering instrument and other documents confirm the facility collects incident-based, uniform data regarding allegations of sexual abuse and sexual harassment. A standardized instrument and specific guidelines and definitions are used to assist in identifying the data.

Provision (d):
The agency shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

The facility maintains and collects various types of identified data and related documents regarding PREA. The Policy and review of the annual report and data gathering instrument and other documents confirm the facility collects incident-based, uniform data regarding allegations of sexual abuse and sexual harassment. A standardized instrument and specific guidelines and definitions are used to assist in identifying the data.

Provision (e):
The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents.

BNJJC does not contract with outside facilities for confinement of its residents.

Provision (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.

The Policy states that upon request, BNJJC shall provide all such data from the previous calendar year to the Department of Justice no later than June 30. A request was not made for the previous calendar year.

Conclusion:
Based upon the review and analysis of the documentation, the Auditor has determined the facility is compliant with this standard regarding data collection.

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.

Documents Reviewed:
Missouri Department of Social Services Data Collection Form
Critical Incident Review Form
PREA Data (Annual Report)

Interviews:
Superintendent
PREA Coordinator

The facility has conducted the 2016/2017 annual report and it is posted on the State of Missouri Department of Juvenile Justice Website. The agency shall prepare an annual report of any findings with corrective actions for each facility, as well as the agency as a whole. The report includes a comparison of the current year's data. The Policy requires the review of data collected and aggregated in order to improve the PREA efforts. The interviews revealed the collected and aggregated data is reviewed to assess and improve the effectiveness of the PREA related initiatives by identifying problem areas; developing and implementing corrective actions where needed; and preparing an annual report based on the collected data. The interviews supported the provisions of the Policy and the standard. The Policy also indicates an annual report will be prepared that will provide information regarding the facility's corrective actions in addressing sexual abuse.

The annual report is approved as required by Policy, per the interviews and a review of the report by the Auditor, the annual report reflects a comparison of the results of annual data, by calendar year. The annual report has been reviewed and the report is accessible to the public through the facility's website. There are no personal identifiers on the annual report.

Conclusion:
Based upon the review and analysis of the documentation, the Auditor has determined the facility is compliant with this standard regarding data review for corrective action.

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.

Documents Reviewed:
Facility Policy 17.12, PREA: Data Collection, Review and Storage
Annual Report

Interviews:
Superintendent
PREA Coordinator

The agency meets the requirements of this standard. State of Missouri has a public website that features all federal PREA reports, PREA brochures, and information regarding PREA. The Agency Policy provides that all data collected will be securely stored and maintained for at least 10 years after the initial collection date, unless State or local statutes require otherwise. According to the facility Policy, the aggregated sexual abuse data will be readily available to the public through the agency's website; the practice is that the report is posted on the agency's website. A review of the annual report verified there are no personal identifiers and it was observed posted on the website, as required. Related documentation in the facility was observed to be securely stored.

Conclusion:
Based upon the review and analysis of the documentation, interviews and observations, the Auditor has determined the facility is compliant with this standard regarding data storage, publication, and destruction.

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 inmates, residents, and detainees? ☒ 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.

PREA audits for the facility have been conducted as required for the initial three-year period. The facility, in conjunction with the Missouri Department of Youth Services, has embarked on fulfilling the auditing requirements for this second three-year period. The facility has provided the Auditor with the required documentation which have maintained as required by the standards and the auditing process.

A comprehensive site review was provided to the Auditor during the site visit and additional documentation was reviewed during the site visit. The staff members were cooperative in providing additional documentation as requested. The Superintendent provided appropriate work spaces which included conditions for conducting interviews in private with the residents and staff.

The posted notices regarding the audit were observed throughout the facility, accessible to residents; staff; visitors; contractors; and volunteers. The notices provided directions and contact information informing those who wanted to contact the Auditor of how to do so. No correspondence was received by the Auditor.

Standard 115.40a: Frequency and scope of audits states that during the three-year period starting on August 20, 2013, and during each three-year period thereafter, the agency ensures that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once. All final reports are posted on the agency website. During this audit, the Auditor had access to previous audits, and had the ability to observe all areas of the audited facility. The Auditor received copies of any relevant documents (including electronically-stored information) requested and was able to conduct private interviews with staff and residents. A review of documentation and interviews with the Administrative and the PREA Manager support the finding that this facility is in compliance with this standard.

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 within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. 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.

This facility was previously audited in 2016 and the Auditor confirmed the audit report was posted on the agency's website as is the practice with the facility. This report does not contain any personal identifying information and there were no conflicts of interest regarding the completion of the audit. The facility policies and other documentation were reviewed regarding compliance with the standards and have been identified in the report. The audit findings were based on a review of policies and procedures and supporting documentation; interviews with staff, residents, contractors and a volunteer; and observations.

The agency has published on its agency website and has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years starting January 2014 through December 2017. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision.

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.

Dwight L. Fondren, CCE November 5, 2018

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.