PREA AUDIT: AUDITOR'S SUMMARY

REPORT JUVENILE FACILITIES

Name of Facility: Datema House				
Physical Address: 918 South Jefferson, Springfield, MO 65806				
Date report submitted: August 23, 2014				
Auditor information: Shirley L. Turner				
Address: 3199 Kings Bay Circle, Decatur, GA 30034				
Email: shirleyturner3199@comcast.net				
Telephone number: 678-895-2829				
Date of facility visit: July 28, 2014				
Facility Information				
Facility Mailing Address: Same as Physical Address				
Telephone Number: 417-895-6830				
The Facility is:	☐ Military	☐ County	☐ Federal	
	☐ Private for profit	☐ Municipal	☒ State	
	☐ Private not for profit			
Facility Type:	☐ Detention	☒ Correction	☐ Other:	
Name of PREA Compliance Manager: Kim Abbott			**Title:**	Youth Facility Mgr.
Email Address: kimberly.abbott@dss.mo.gov			**Telephone Number:**	417-895-6830
Agency Information				
Name of Agency: Division of Youth Services				
Governing Authority or Parent Agency: Department of Social Services				
Physical Address: 419 Knipp Drive, Jefferson City, MO 65102				
Mailing Address: PO Box 447, Jefferson City, MO 65102				
Telephone Number: 573-751-3324				
Agency Chief Executive Officer				
Name: Phyllis Becker			**Title:**	Interim Division Director
Email Address: phyllisbecker@dss.mo.gov			**Telephone Number:**	573-751-3324
Agency Wide PREA Coordinator				
Name: Judy Parrett			**Title:**	Assistant Deputy Director
Email Address: judy.parrett@dss.mo.gov			**Telephone Number:**	573-751-3324

AUDIT FINDINGS

NARRATIVE:

The Datema House is located in Springfield, Missouri and is operated by the Department of Social Services, Division of Youth Services (DYS). It is a community based minimum security facility that serves male juvenile offenders between the ages of 12 and 17. The average length of stay is approximately three and a half months. The facility capacity is 12. Thirty-seven residents have been admitted to the Datema House in the past 12 months.

Sixteen staff members have been employed at the facility during the past year. On-site medical services, including an evaluation and screening for any medical needs, are provided by a full-time Licensed Practical Nurse. The medical oversight is provided by a regional Registered Nurse who visits the facility one to two times per month. The residents are taken to a local physician for a general physical examination and to address any current medication issues, if needed. Monthly psychiatry encounters, with a child psychiatrist, are scheduled if the youth is taking psychotropic medications and meetings are scheduled as needed. The encounters with the psychiatrist are through tele-health; the television system is located at another local DYS facility. Medical and mental health follow-up treatment services may be arranged in the community if recommended. Education services are provided by the facility by a certified teacher and an education assistant.

The Datema House treatment program consists of two phases, In-House and Transitional. The In-House Phase is the time a resident spends in the facility working on their individual program. During this phase the resident is expected to develop consistent positive habits and behaviors to prepare them for their return home and to the community. The Transitional Phase is the time where the resident spends part of the week in the facility and the other part at home. This time allows the resident and family to adjust to the resident's return home. Also, during the Transitional Phase, the resident and family are provided time to work on any issues they may have with the support of the Datema House staff.

DESCRIPTION OF FACILITY CHARACTERISTICS:

The program is located on a ¼ to ½ acre lot in four buildings in a residential and business area near downtown Springfield, Missouri. The main building is a large house that consists of a main floor, upstairs second floor, and the basement. The upstairs or second floor is used as the housing area with two bedroom areas, a single bathroom and a double bathroom. The bathrooms provide reasonable privacy for each resident. A dayroom or TV room is also located in this upstairs area. On the main or first floor is the dining room, where residents and staff eat their meals family style. The main floor also contains the front foyer; kitchen; food pantry; closets; and staff bathroom. The basement contains the laundry area and adds additional storage space. The basement also serves as the storm shelter for the facility.

Next door to the main building is a smaller house that is used for education services. The library is located in the school building, adjacent to a large classroom. This building also contains two offices, a small testing room, a bathroom, and a kitchen where the stove/oven has been disconnected. Behind

the school is a small shed used for storage. The annex, located behind the main house, contains a large room that serves as a multi-purpose area. Located in a section of the room is weight equipment that the residents use during physical education. The outside grounds area behind the main house and the school is used for recreation and leisure activities. The grounds and buildings present a homey, comfortable environment.

SUMMARY OF AUDIT FINDINGS:

The notifications of the on-site audit were posted in various parts of the facility at least six weeks prior to the site visit. Photographs were taken of the various sites where the notices had been posted and the photographs were electronically sent to this Auditor, noting their locations. The Pre-Audit Questionnaire and the supporting documentation were uploaded to a flash drive, which was received approximately four weeks prior to the on-site audit. After reviewing the information, a telephone call was made by the Auditor to clarify information.

The on-site audit was conducted July 28, 2014. An entrance meeting was held and after the meeting a comprehensive tour of the facility was conducted by a resident of the Datema House, accompanied by the Youth Facility Manager who also serves as the PREA Compliance Manager. During the tour, staff members were observed to be directly supervising and engaging the residents. Random staff, specialized staff and the eight residents present in the program were interviewed during the on-site audit process. The interviews of both staff and residents revealed how well both groups have been educated regarding PREA issues. All staff interviewed expressed awareness of their duties and responsibilities as they relate to the safety of the residents and PREA compliance. The residents interviewed demonstrated their knowledge of what PREA means and how to report sexual assault and sexual harassment.

The information for the audit process was provided in an organized manner both on the thumb drive and during the on-site audit. A close-out meeting was held at the conclusion of the on-site audit and a summary of the audit findings was provided.

Number of Standards Exceeded: 0

Number of Standards Met: 40

Number of Standards Not Met: 0

Number of Standards Not Applicable: 1

Standard 115.311 Zero Tolerance of Sexual Abuse and Sexual Harassment.

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

DYS Policy 9.18 provides guidelines for implementing the agency's approach to complying with the requirements of the PREA standards including, zero tolerance toward all forms of sexual abuse and sexual harassment. The policy contains definitions of the prohibited behaviors and sanctions for those who participate in such behaviors. Policies 3.8, 3.23, and 9.28 also support this standard. The Youth Facility Manager has been identified as the PREA Compliance Manager.

Standard 115.312 Contract With Other Entities for the Confinement of Residents.

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

The agency has entered into or renewed 12 contracts for the confinement of residents in the past 12 months. Contractors are required to adopt and comply with the PREA standards.

Standard 115.313 Supervision and Monitoring

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policies 9.6 and 9.8 provides for the implementation of a staffing plan with adequate staffing levels to protect residents against sexual abuse. A review of the Direct Care Staffing Pattern document and interviews with staff revealed that at least two staff members are present on each shift. The facility reports no deviations from the staffing plan in the past 12 months. The annual assessment of the staffing has been conducted to determine whether adjustments are needed in accordance with the standard. A review of the staffing plan is documented, indicating that the staffing ratios are regularly met.

The Youth Facility Manager and the Social Services Manager, Band 1 documented unannounced rounds of the facility for the maintenance of a safe environment. A review of the Unannounced Program Visit form and staff interviews confirmed the practice of unannounced rounds.

Standard 115.315 Limits to Cross Gender Viewing and Searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor Comments:

DYS Policy provides for same gender pat-down searches absent exigent circumstances. There have been no cross gender pat-down searches during this audit period. Policy 5.8 prohibits staff from conducting cross-gender strip or cross-gender visual body cavity searches of residents. Policy 9.18 procedures have been implemented that provide for residents to shower, perform bodily functions, and change clothes without being observed by non-medical staff of the opposite gender. Interviews with staff and residents confirm the practices.

Policy 7.2 states that staff shall not search a transgender or intersex resident to determine the resident's genital status. All direct care staff members have been trained on conducting cross-gender pat-down searches and searches of transgender and intersex residents.

Standard 115.316 Residents With Disabilities and Residents Who are Limited English Proficient

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

DYS contracts for statewide support services to provide residents with disabilities and residents who are limited English proficient with various services so that they may benefit from and participate in resident education regarding PREA. The resident education material is available in another dominant language other than English. A review of documentation and staff interviews confirmed these practices. Policy 9.18 states that the facility will not rely on resident interpreters, resident readers or any kind of resident assistance except when a delay in obtaining interpreter services would jeopardize a resident's safety.

Standard 115.317 Hiring and Promotion Decisions

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

DYS policy 9.18 provides for annual background checks on all employees and a process that is aligned with the standard. A review of documentation and interviews with staff confirmed that prior to the hiring of an employee or contractor, background checks are conducted.

Standard 115.318 Upgrades to Facilities and Technology

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

☒ Standard Not Applicable

Auditor Comments:

The Datema House does not use any type of electronic monitoring technology. DYS has not acquired any new facilities since August 20, 2012.

Standard 115.321 Evidence Protocol and Forensic Medical Examinations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 9.18 addresses this standard. DYS does not conduct administrative or criminal investigations of sexual abuse or sexual harassment. Investigations are conducted by Missouri Children's Division Out of Home Investigation Unit (CD-OHI) for residents under the age of 18. They receive reports through their hotline number made by DYS staff, resident, parent/guardian, or external entity on behalf of the resident. If law enforcement is not already involved, CD-OHI contacts the appropriate law enforcement agency to co-investigate. Allegations of sexual abuse of residents 18 years old and over are referred to the Division of Legal Services Investigation Unit.

Forensic medical examinations will be completed at no financial cost to the victim. There have been no forensic examinations in the last 12 months. Although a MOU has not been signed, there is a documented verbal agreement that victim advocacy services will be provided by the Child Advocacy Center, Inc. Documentation of attempts to secure a MOU with the advocacy agency were reviewed and the information was confirmed with the representative from the advocacy agency. There is also a qualified agency staff member that can provide crisis intervention if requested.

Standard 115. 322 Policies to Ensure Referrals of Allegations for Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 9.18 provides that staff report all allegations of sexual abuse and sexual harassment through the Missouri Children's Division hotline. The appropriate State investigative entity, CD-OH or DLS, will be contacted and they will contact the local law enforcement agency regarding the investigation of the allegation. There have been no allegations of sexual abuse or sexual harassment reported at the Datema House during the past 12 months. The DYS website contains information regarding how investigations of allegations of sexual abuse are handled.

Standard 115.331 Employee Training

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 3.18 provides for the PREA training. The staff training is comprehensive and covers all of the key areas referenced in the standard: zero tolerance policy; sexual abuse and sexual harassment prevention, detection, response, and reporting; resident's rights to be free of sexual abuse and sexual harassment; dynamics of sexual harassment and sexual assault; avoiding inappropriate relationships with residents; and detecting and responding to signs of threatened and actual sexual abuse. A review of the training documentation and the results of staff interviews confirm that training occurs.

Standard 115. 332 Volunteer and Contractor Training

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 3.18 contains information regarding the training of volunteers and contractors who have contact with residents. Receipt of the training is documented and it contains a review of the agency's zero tolerance policy.

Standard 115.333 Resident Education

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 9.5 requires that residents receive information about the facility's zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. In the past 12 months 37 residents received the information. Residents are provided with and receive a review on a handout entitled "Safety 1st". Resident and staff interviews and documentation of residents' signatures confirm that the residents receive the education regarding PREA during the intake process and periodically during their stay. DYS has statewide contracts to provide support services in accessible formats for residents who are limited English proficient, deaf, visually impaired, or otherwise disabled.

Standard 115.334 Specialized Training: Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

DYS does not conduct administrative or criminal investigations. Documentation exists indicating that PREA requirements for specialized training for investigators who investigate allegation of sexual abuse and sexual harassment in confinement were provided to CE-OHI and DLS.

Standard 115.335 Specialized Training: Medical and Mental Health Care

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 3.18 addresses PREA training for medical staff. A certificate documenting the Nurse's completion of specialized training offered on-line by the National Institute of Corrections was reviewed. The Nurse does not conduct forensic medical examinations.

Standard 115.341 Screening for Risk of Victimization and Abusiveness

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policies 6.7, 9.5, and 9.18 address this standard. A review of documentation and staff and resident interviews confirm that screening for risk of sexual abuse victimization or sexual abusiveness toward other residents is being conducted on each resident. The initial screening is done during the intake process and residents receive reassessments every six months. Interviews with residents and staff confirm the practice.

Standard 115.342 Use of Screening Information

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 9.18 prohibits placing gay, bisexual, transgender, or intersex residents into confinement based solely on such identification or status. Housing and program assignments require determinations on each transgender or intersex resident on a case by case basis. The facility prohibits considering gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive. There have been no residents placed in isolation in the last 12 months because of victimization.

Standard 115.351 Resident Reporting

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 9.18 provide for internal ways a resident may report allegations of sexual abuse; sexual harassment; retaliation for reporting; and staff neglect or other violations that led to abuse. A resident may file a grievance or a written complaint; write a note; talk to any staff member; and third parties may report allegations to staff. The grievance/complaint and other written requests may be given to staff or placed in the locked box located in the dining room. An assortment of PREA related information, including grievance/complaint forms are located on a wall in the upstairs housing area, accessible to the residents. A telephone is also located on the main floor in the dining room and the Missouri Children's Division Child Abuse and Neglect hotline is accessible for the residents to use to report allegations to an outside entity. The hotline number is also accessible from any office phone. National hotline numbers and a website to connect to the local hotline number are available to residents.

Missouri State Law provides for staff to report allegations of sexual abuse to the Abuse and Neglect hotline without the need for supervisory approval. Interviews revealed that staff members are aware of their responsibility to report sexual abuse and sexual harassment. They are also aware that they are to accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties.

Standard 115.352 Exhaustion of Administrative Remedies

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Residents may put a written complaint in the designated locked box located in the dining room or give the document to staff. There have been no complaints relating to sexual abuse or sexual harassment received in the past 12 months. Staff and resident interviews confirmed their knowledge of how to use the locked box to report sexual abuse or sexual harassment.

Standard 115.353 Resident Access to Outside Confidential Support Services

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 9.18 requires the facility to provide the residents with access to outside victim advocacy services. Documentation was provided by the facility that support attempts to establish a MOU with a local victims' advocate agency. The agency has agreed to provide services but unwilling at this time to sign a MOU. Correspondence and a telephone conversation with the representative from the victim advocacy agency indicate that services will be provided to the facility when requested.

Standard 115.354 Third-Party Reporting

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

The DYS website provides the public with information regarding third-party reporting of abuse. Parents receive information about reporting incidents of sexual abuse through their copy of the Youth/Guardian Program Manual. Staff and resident interviews were aligned with this information.

Standard 115.361 Staff and Agency Reporting Duties

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

According to Policy 9.18 and Missouri Revised Statute 210, all staff members are mandated reporters. They are to immediately report any knowledge, suspicion or information they receive regarding sexual abuse and sexual harassment, retaliation against residents or staff who report any incidents or any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Staff interviews support this information.

Standard 115.362 Agency Protection Duties

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 9.18 addresses this standard and provides that when the agency or facility learns that a resident is subject to substantial risk of imminent sexual abuse, it takes immediate action to protect the resident. There have been no incidents in the last 12 months where the agency or the facility took any action in regards to a resident being in substantial risk of imminent sexual abuse. Policy guides the response to this standard if it becomes necessary.

Standard 115.363 Reporting to Other Confinement Facilities

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policies 9.18 and 3.8 address this standard. Upon receiving an allegation that a resident was sexually abused while confined in another facility, the PREA Compliance Manager will notify the head of that facility within 72 hours, according to Policy 9.18. The PREA Compliance Manager will ensure that the allegation is investigated according to Policy 3.8 and the standard. In the past 12 months, there have not been any allegations of sexual abuse occurring to a Datema House resident while he was in another facility.

Standard 115.364 Staff First Responder Duties

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

The DYS First Responder Protocols for Sexual Abuse provide a detailed account of first responder duties and responses. There have been no allegations that a resident was sexually abused within the last 12 months. Staff interviews confirmed that they are knowledgeable of their duties as a first responder.

Standard 115.365 Coordinated Response

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

A review of the written document, DYS Coordinated Response to Reports of Sexual Abuse, and interviews with staff confirm that an institutional plan has been developed. The plan coordinates the actions to be taken among facility first responders and other staff, in response to an incident of sexual abuse.

Standard 115.366 Preservation of Ability to Protect Residents from Contact with Abusers

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

The current labor agreement resolution is dated 12/1/2010 -11/30/2013. Documentation was provided which shows that it has been extended through 11/30/14. The State of Missouri Office of Administration and Department of Social Services has entered into an agreement with the Communications Workers of America (CWA) Local 6355, AFL-CIO and the agreement is consistent with provisions of the applicable PREA standards.

Standard 115.367 Agency Protection Against Retaliation

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Comprehensive Policy 9.18 and Department of Social Services Policy 2-102 address protection against retaliation. The Youth Facility Manager and the Group Leader have been identified as the staff members designated with monitoring for possible retaliation at the Datema House. If the conduct is identified the monitoring would be conducted no less than 90 days; and longer if indicated. Policy 9.18 also instructs staff on reporting incidents of retaliation. There have been no incidents or allegations of sexual abuse within the last 12 months.

Standard 115.368 Post Allegation Protective Custody

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policies 9.8 and 9.18 address this standard and cover the requirements of how protective custody is to be used. The Datema House does not have an isolation room. There have been no allegations of sexual abuse or sexual harassment during the last 12 months and not a need for post allegation protective custody.

Standard 115.371 Criminal and Administrative Agency Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

According to Policy 9.18, DYS refers criminal and administrative investigations to external agencies. An investigation is not terminated solely because the source of the investigation recants the allegation. Substantiated allegations of conduct that appears to be criminal are referred for prosecution.

Standard 115.372 Evidentiary Standards for Administrative Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

The Missouri Child Welfare Manual states that a standard of preponderance of the evidence or a lower standard of proof is used for determining if allegations are substantiated.

Standard 115.373 Reporting to Residents

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 9.18 provides the process for notifying residents, following an investigation, of whether an allegation has been determined to be substantiated, unsubstantiated, or unfounded. There has not been an allegation of sexual abuse in the past 12 months.

Standard 115.376 Disciplinary Sanctions for Staff

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 9.18 provides for disciplinary sanctions for staff to be up to and including termination for violation of the sexual abuse and sexual harassment policies. The policy requires that the violation be reported to local law enforcement. In the past 12 months, no staff has been terminated or has resigned for violating agency PREA related policies.

Standard 115.377 Corrective Action for Contractors and Volunteers

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 9.18 addresses the corrective actions regarding any contractor or volunteer engaging in sexual abuse of residents. They will be reported to local law enforcement unless the activity was clearly not criminal and to relevant licensing bodies. The Policy requires the facility to take remedial measures and prohibit future contact with residents in the case of any violation of the facility's PREA related policies by contractors or volunteers. During the past 12 months, no contractor or volunteer has been reported to law enforcement or any investigative entity for allegations of sexual abuse.

Standard 115.378 Disciplinary Sanctions for Residents

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 9.18 addresses this standard. Any resident found in violation of the facility's zero tolerance policy against sexual abuse, assault, conduct or harassment will be offered counseling or other interventions designed to address and correct the underlining reasons for their conduct. The Youth/Guardian Program Manual includes inappropriate physical contact in the discussion of consequences regarding serious rule infractions. There has been no incident of resident-on-resident sexual abuse in the past 12 months.

Standard 115.381 Medical and Mental Health Screenings; History of Sexual Abuse

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 9.18 states that residents who disclose a history of sexual abuse or who disclose previously perpetrating sexual abuse will be offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. Staff interviewed confirmed awareness of the policy and the requirements of the standard.

Standard 115.382 Access to Emergency Medical and Mental Health Services

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 9.18 requires timely access to emergency medical treatment and crisis intervention services for victims of sexual abuse. Treatment services will be provided to every victim. The nature and scope of the services are determined by medical and mental health practitioners according to their professional judgment.

Standard 115.383 Ongoing Medical and Mental Health Care for Sexual Abuse Victims and Abusers

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 9.18 provides for ongoing medical and mental health care for sexual abuse victims. It also provides for medical and mental health evaluations and appropriate treatment in accordance with the standard. Care is consistent with the community level of care, which was confirmed by staff interviewed. There have been no sexual assault victims in the past 12 months.

Standard 115.386 Sexual Abuse Incident Reviews

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policies 9.17 and 9.18 address this standard. There have not been any criminal investigations conducted at the Datema House in the last 12 months; however, the policies will serve as the guide for staff in conducting incident reviews. The incident review team has been identified.

Standard 115.387 Data collection

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 9.18 requires the collection of accurate, uniform data for every allegation of sexual assault. DYS has a data collection instrument to answer all questions for the US Department of Justice Survey of Sexual Abuse Violence. A review of the annual report revealed it was completed according to this standard.

Standard 115.388 Data Review for Corrective Action

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 9.18 addresses this standard. The DYS annual report reveals no sexual abuse allegations within the past 12 months. Policy 9.18 requires the review of data for corrective action to improve the effectiveness of its prevention, protection and response policies, practices and training.

Standard 115.389 Data Storage, Publication and Destruction

☐Exceeds Standard (substantially exceeds requirement of standard)

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

☐Does Not Meet Standard (requires corrective action)

Auditor Comments:

Policy 9.18 addresses this standard and requires that data is collected and securely retained for 10 years. The aggregated PREA data is reviewed and all personal identifiers are removed.

AUDITOR CERTIFICATION:

The auditor certifies that the contents of the report are accurate to the best of her knowledge and no conflict of interest exists with respect to her ability to conduct an audit of the agency under review.

Shirley L. Turner

Auditor Signature

August 23, 2014

Date