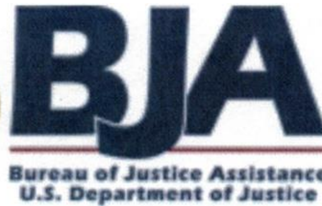
PREA AUDIT: AUDITOR'S SUMMARY REPORT

JUVENILE FACILITIES



Name of Facility: Girardot Center for Youth and Families

Physical Address: 609 North Middle Street, Cape Girardeau, Missouri 63701-4840

Date report submitted

Auditor information: Flora Boyd

Address: 5 Rosemount Court, Blythewood, South Carolina

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Telephone number: (803) 312-5199

Date of facility visit: June 9, 2014

Facility Information

Facility Mailing Address: same as above
(if different from above)

Telephone Number: 573-290-5860

The Facility is:	Military	County	Federal
	☐Private for profit	☐Municipal	☐**X** State
	☐Private not for profit	☐	☐

Facility Type:	☐Detention	**X** Correction	Other:

Name of PREA Compliance Manager: ☐	☐ **Lori Blattner** ☐	**Title:**	**Youth Facility Manager II**
Email Address: lori.blattner@dss.mo.gov		**Telephone Number:**	**573-290-5860**

Agency Information

Name of Agency: Missouri Division of Youth Services

Governing Authority or Parent Agency: *(if applicable)*

Missouri Department of Social Services

Physical Address:3418 Knipp Drive, Jefferson City, Missouri 65102

Mailing Address: *(if different from above)* **PO Box 447, Jefferson City, Missouri 65102**

Telephone Number: 573-751-3324

Agency Chief Executive Officer

Name: Phyllis Becker	**Title:**	**Interim Division Director**
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Agency Wide PREA Coordinator

Name: Judy Parrett	**Title:**	**Assistant Deputy Director**
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AUDIT FINDINGS

NARRATIVE:

The Girardot Center for Youth and Families (GCYF) is a 24-bed residential treatment facility for male adolescents between the ages of 12 to 18 years. Located in Cape Girardeau, Missouri, the GCYF is governed by the Missouri Division of Youth Services (DYS), a division of the Missouri Department of Social Services. The length of stay in the program is based upon residents completing their individual treatment goals and program expectations; however, the average length of stay is six months. Youth are committed by a juvenile court order.

GCYF employs 32 full-time staff. In addition to a full-time licensed practical nurse, a contract psychiatrist and two contract nurse practitioners are available to address resident's medical and mental health needs. Eighteen direct care staff and two group leaders and teachers form two treatment teams which provide constant supervision and program activities for the residents. A service coordinator determines resident's treatment needs and ensures continuity of treatment services from intake to release.

The treatment program is based on the principles of Adlerian Psychology, Situational Leadership and Group Dynamics. In a therapeutic setting, the four basic areas of concentration include, pro-social skills, bonding, employability and education. The education program is congruent with the local public school system based on resident's individual needs. Family involvement is encouraged at all levels and components of the program.

DESCRIPTION OF FACILITY CHARACTERISTICS:

GCYF consists of four buildings including an administration/education building, two residential cottages and a cafeteria. Each cottage, which houses 12 residents, has a multi-purpose lounge/dining area and an open bay style living area where bunk beds are arranged in a manner to allow for constant supervision by the direct care staff. There is a central bathroom, a laundry room and two office areas. There is a full basement used for various group activities and storage. The facility does not have a surveillance system in place.

SUMMARY OF AUDIT FINDINGS:

The notification of the on-site audit was posted on May 5, 2014, six weeks prior to the date of the on-site audit. The posting of the notices was verified by photographs received electronically from the PREA Coordinator. The photographs indicated notices were posted in various locations throughout the facility including the residential cottages, administrative areas and cafeteria.

The Pre-Audit Questionnaire, policies and supporting documentation were received on May 16, 2014. The documents, which were uploaded to a UBS flash drive, were well organized and easy to navigate. The initial review revealed the need for corrective action in regard to some DYS policies and

procedures which did not sufficiently address standards and for some standards adequate documentation was not provided. After discussing concerns with the PREA Coordinator and GCYF PREA Compliance Manager, steps were taken to address each policy concern and required documentation was also provided. Specific actions taken to correct these findings are summarized in this report under the related standard.

The on-site audit was conducted on June 9, 2014. After meeting with the facility's management staff, a complete guided tour of the facility was led by residents. During the tour, residents were observed to be under constant supervision of the staff while involved in school and other activities. There was information regarding PREA posted in the cottages and in the cafeteria.

During the on-site visit, seven staff including those from all three shifts were interviewed. Overall, the interviews revealed staff are knowledgeable of PREA standards and were able to articulate their responsibilities. Six residents were also interviewed. Residents were well informed of their right to be free from sexual abuse and harassment, how to report sexual abuse and harassment, and the services that the community based victims advocate provides.

The community victims' advocacy service, Beacon Health Center was contacted to verify the scope of services provided as specified in the Memorandum of Understanding (MOU) they have with GCYF. There were no calls received from GCYF residents over the past year.

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)

X 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 initial review of DYS Policy 9.18 PREA revealed the policy did not address sanctions for those residents found to have participated in prohibited behaviors however the policy was enhanced to include sanctions for residents. The policy is in full compliance with the standard.

The policy outlines how the facility carries out its approach to preventing, detecting and responding to sexual abuse and harassment, includes definitions of prohibited behaviors and sanctions for those found to have participated in prohibited behaviors. The policy also provides strategies and responses for reducing and preventing sexual abuse and harassment.

The Facility Manager, who also serves as the PREA Compliance Manager, has sufficient time to oversee the facility's PREA compliance efforts and perform other duties.

Standard 115.312: Contract with other entities for the confinement of residents.

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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 has entered into/renewed 12 contracts for confinement of residents in the past 12 months. Reviewed contracts require DYS to monitor the contractor's compliance with PREA.

Standard 115.313: Supervision and Monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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 initial policy review revealed specific staffing ratios of 1:8 during waking hours and 1:16 during sleeping hours were not included in DYS Policy 9.6 Program Supervision. Documentation provided for the facility's staffing plan was not sufficient and there was no documentation of an annual review of the staffing plan. Corrective action included adding the specific ratios to the policy as required by the standard, the development of a staffing plan and an annual review of the staffing plan was conducted and documented.

GCYF utilize constant staff monitoring instead of video monitoring to protect residents from sexual abuse and harassment. The Facility Manager conducts and documents unannounced rounds on all shifts and in all areas of the facility to monitor and deter staff sexual abuse and harassment.

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:

The initial review of DYS Policy 9.18 PREA revealed the policy did not adequately state that residents are able to shower, perform bodily functions and change clothing without non-medical staff of the opposite gender viewing them. Also, the training curricula did not indicate that staff receive training on conducting searches of transgender and intersex residents. Corrective action was taken to re-write the section of the policy to ensure compliance with this standard, and training was provided and documented regarding conducting searches of transgender and intersex residents.

The policy limits pat-down searches to same gender staff absent exigent circumstances. This was verified during interviews with residents. There were no cross-gender pat-down searches conducted during the past 12 months.

Staff and resident interviews indicated that female staff, volunteers and contractors entering the housing unit do not consistently announce themselves. The facility manager took corrective action by sending out a directive to all staff that females entering a cottage must announce themselves. Staff were required to sign acknowledgement of the directive and the documentation was provided.

DYS Policy 9.18 PREA prohibits the search of a transgender or intersex resident solely for the purpose of determining the resident's genital status and staff interviews verified compliance. Staff training records and staff interviews confirmed that 100% of the staff received training on cross-gender pat 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 services to provide residents with disabilities and residents who are limited English proficient with various services on an as needed basis.

DYS Policy 9.18 PREA ensure residents with disabilities or who are limited English proficient are provided meaningful access to all aspects of the facility's efforts to prevent, protect and respond to sexual abuse and harassment. This policy also states the facility will not rely on resident interpreters, resident readers or any kind of resident assistants except when a delay in obtaining interpreters services could jeopardize a residents' safety. Resident and staff interviews verified the facility does not use resident assistants and there were no instances of resident interpreters or readers being used in the past 12 months.

Staff training materials contained information on providing appropriate explanations regarding PREA to residents based upon the individual needs of the youth.

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 PREA did not specifically address that material omission regarding misconduct or provision of materially false information will be grounds for termination. Corrective action was taken by adding these requirements to the policy. Documentation was provided that staff hired had documented criminal background checks and the questions regarding past conduct were asked and responded to during the hiring process. Additionally, volunteers who have contact with residents have documented criminal background checks.

According to DYS Policy 9.18 PREA, background checks are to be conducted every year.

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)

☐ **X** Does Not Apply

Auditor Comments:

DYS has not acquired any new facilities since August 20, 2012 and the facility does not use any form of technology to monitor residents or the physical plant.

Standard 115.321: Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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:

Initial review of DYS Policy 9.18-PREA revealed the policy did not address that forensic exams are offered without financial cost to the victim; however, a sentence was added to the policy to ensure compliance. The policy requires that all allegations of sexual abuse and sexual harassment be referred to the appropriate investigative agency based upon the victim's age.

GCYF has a Memorandum of Understanding with the Beacon Health Center to provide confidential emotional support to residents who are victims of sexual abuse and forensic exams. Documentation was provided that the medical examiners at the Beacon Health Center are SAFE certified.

The Missouri Children's Division Out-of-Home Investigation Unit (CD-OHI) investigates allegations of sexual abuse and sexual harassment for residents under the age of 18. They receive reports through their hotline. CD-OHI will contact the appropriate local law agency to co-investigate. Residents 18 years of age are referred to the Division of Legal Services Investigation Unit (DLS). DLS contacts the appropriate law enforcement agency to co-investigate allegations of sexual abuse and sexual harassment.

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:

DYS Policy 9.18 PREA and the DYS Functional Practices requires staff to refer all allegations of sexual abuse and sexual harassment to the Missouri Children's Division Hotline. CD-OHI or DLS will contact the appropriate law enforcement agency and co-investigate the allegations. There were no allegations of sexual abuse or sexual harassment in the past 12 months. DYS's website includes its Fundamental Practices which describes how investigative responsibilities are handled for allegations of sexual abuse.

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:

DYS Policy 3.18 Training, the training curriculum, staff training records and staff interviews revealed staff receive PREA training during initial training and annually during refresher training. Specific topics covered during PREA training are consistent with this standard's requirements and is tailored to the facility's male resident population. All employees are trained as new hires regardless of their previous experience. Employees training records are maintained electronically and comprehension of PREA training was verified during staff interviews.

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:

DYS Policy 3.18 Training requires volunteers and contractors who have contact with residents to receive PREA training. The policy requires the appropriate supervisor to provide training to the volunteer/contractor and the training is documented. An interview with a volunteer revealed she was knowledgeable concerning her responsibilities relative to PREA and the agency's zero tolerance policy regarding sexual abuse and harassment. Volunteers and contractors also sign documentation acknowledging that they understand the training they received.

Standard 115.333: Resident Education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor Comments:

DYS Policy 9.5 Residential Care requires residents to receive training information regarding safety, their rights and how to report sexual abuse and harassment immediately upon arrival. The remainder of the training is completed within 10 days of arrival. Residents are provided a handout entitled "Safety First" which includes information on prevention/intervention, self-protection, reporting and treatment/counseling. During intake, staff review the handout with the residents and residents sign verifying receipt of the information. Documentation of resident's signatures were reviewed and confirmed during resident interviews. All residents interviewed stated they received this information the same day they arrived at the facility and periodically thereafter.

Staff present PREA information in a manner that is accessible to all residents. If needed, the facility has statewide contracts to provide translation services, hearing and visual impairment services for residents with disabilities or who may be limited English proficient.

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; however, documentation was reviewed indicating that PREA requirements for specialized training for investigators who investigate allegation of sexual abuse and sexual harassment in confinement was provided to CD-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:

DYS Policy 9.3 Training requires PREA training and specialized training for medical staff. Initial review of training documentation revealed medical staff only received the basic PREA training provided to all staff. Corrective action was taken and a certificate documenting the nurse's participation in specialized training offered on-line by the NIC Learning Center was provided. The nurse does not conduct forensic 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:

DYS Policy 9.05 Residential Care requires staff to screen each resident for risk of victimization upon arrival at the facility and DYS Policy 6.7 Administrative Case Review requires staff to reassess residents every six months thereafter. DYS Policy 4.1 Official Case File Requirements and Maintenance limits staff access to this information on a "need to know basis". Documentation and resident interviews revealed that risk screenings are being conducted; however, staff and resident interviews indicated they were not asked whether they identified with being gay, bi-sexual, transgender or intersex. Corrective action was taken immediately to update the risk of victimization screening form to ensure residents are asked the question so the response is not solely based upon the interviewer's perception. Documentation confirming use of the revised screening form has been verified.

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:

GCYF has two housing cottages with open bay style housing with six double bunk beds. Victimization screening information may be used to determine a resident's bed assignment and its proximity to direct care staff in the housing unit to ensure resident's safety.

DYS Policy 9.18 precludes gay, bi-sexual, transgender and intersex residents being placed in a particular housing unit. Staff interviews also verified compliance with this standard.

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:

DYS Policy 9.18 PREA provides multiple internal ways for residents to report sexual abuse and harassment including telling staff member and putting a written complaint in the PREA designated box. While touring the cafeteria, an area with PREA materials including posters and brochures was observed. Upon inquiring about how residents are able to call the hotline or victims advocate, residents leading the tour explained that they have to seek permission from staff to call the hotline or the victims advocate. Corrective action was taken to provide unfettered access to a telephone in each of the two housing cottages. The facility provides residents with the address for the Beacon Health Center Victims Assistance Program so they can also write to them. Resident and staff interviews along with the resident's handbook and posted signs verified compliance with this standard.

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:

DYS does not have administrative procedures for dealing with resident's grievances regarding sexual abuse or harassment. Residents may put a written complaint in the designated PREA box located in their housing cottage. 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 PREA 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:

DYS Policy 9.18 PREA ensures that residents are provided access to outside confidential support services. The facility has a MOU with the Beacon Health Center to provide emotional support and to conduct forensic examinations. The Beacon Health Center was contacted and confirmed that they have received no calls from residents at GCYF in the past 12 months. They also described the emotional support and counseling services that they are able to provide to residents who may be victims of sexual abuse. Resident interviews revealed they are knowledgeable of how to access this service and they were able to describe services offered.

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. Also, parents receive information regarding third–party reporting. Resident interviews revealed their awareness of reporting sexual abuse or harassment to others outside of the facility.

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:

All GCYF's staff are mandated reporters as required by DYS Policy 9.18 PREA and Missouri Revised Statutes 210 to immediately report any knowledge, suspicion or information they receive regarding sexual abuse and 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. Random staff interviews also helped to verify the facility's compliance with this standard.

An interview with the nurse confirmed her responsibility to inform residents 18 years old of her duty to report and limitations of confidentiality.

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:

DYS Policy 9.18 requires that immediate action to be taken upon learning that a resident is subject to a substantial risk of imminent sexual abuse. There were no residents determined to be subject to substantial risk of imminent sexual abuse in the past 12 months. Interviews with the Facility Manager and other random staff verified compliance with this standard.

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:

DYS Policy 9.18 requires the PREA Compliance Manager to notify the head of the other facility within 72 hours upon receiving an allegation that a resident was sexually abused while confined at another facility. During the past 12 months, GCYF received no allegation that a resident was abused while confined at another facility nor were there any allegations received from 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:

DYS Policy 9.18 PREA requires staff to take specific steps to respond to a report of sexual abuse including; separating the alleged victim from the abuser; preserving any crime scene within a period that still allows for the collection of physical evidence; request that the alleged victim not take any action that could destroy physical evidence; and ensure that the alleged abuser does not take any action to destroy physical evidence, if the abuse took place within a time period that still allows for the collection of physical evidence. There were no allegations of sexual abuse during the past 12 months. Random staff interviews revealed considerable knowledge of actions to be taken upon learning that a resident was sexually abused.

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:

DYS has a written facility plan to coordinate actions taken in response to an incident of sexual assault among staff first responders, medical, and facility leadership. Interviews with the Facility Manager and other staff revealed that they are knowledgeable of their duties in response to a sexual assault.

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 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 PREA standards 115.372 and 115.376.

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:

DYS Policy 9.18 PREA requires the monitoring of residents and staff who have reported sexual abuse and sexual harassment or who have cooperated in a sexual abuse or harassment investigation. The monitoring will take place for a period of 90 days or longer, as needed. The Facility Manager and the two Group Leaders are charged with monitoring for possible retaliation. There were no incidents of retaliation in the past 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:

DYS Policy 9.18 PREA provides guidelines for the use of room restriction as a last measure to keep residents who alleged sexual abuse safe and then only until an alternative means for keeping the resident safe can be arranged. No residents have alleged sexual abuse in the past 12 months.

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:

DYS Policy 9.18 PREA requires staff to report allegations of sexual abuse to the hotline. CD-OHI or DLS (depending on the age of the resident) will co-investigate with the appropriate local law enforcement agency. There were been no investigations of alleged resident sexual abuse in the facility in the past 12 months.

Standard 115.372 Evidentiary standards for administrative investigation

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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 (section 2, chapter 4) states a standard of preponderance of evidence or lower standards of proof is used for determining if allegations are substantiated.

Standard 115.373: Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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:

In view of the fact that there were no criminal or administrative investigations during the past 12 months, there have been no notices sent to residents. DYS Policy 9.18 indicates the process for notifying residents whether the allegation proves substantiated, unsubstantiated or unfounded. The PREA Compliance Manger interview confirmed her knowledgeable of the reporting process.

Standard 115.376: Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

X 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 PREA requires staff disciplinary sanctions up to and including termination for violating facility's sexual abuse or harassment policies. The policy also mandates that the violation be reported to law enforcement. No employees have been terminated or disciplined in the past 12 months for violation of the facility's sexual abuse or harassment 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:

DYS Policy 9.18 PREA requires that volunteers and contractors in violation of the facility's policies and procedures regarding sexual abuse and harassment of residents will be reported to local law enforcement unless the activity was clearly not criminal and to relevant licensing bodies. There have been no volunteers or contractors reported in the past 12 months.

The policy also requires the facility staff to take remedial measures and prohibit future contact with residents in the case of any violation of the facility's sexual abuse and harassment policies by contractors or volunteers. This was verified during an interview with the Facility Manager.

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:

As a residential treatment facility, DYS Policy 9.18 mandates that any resident found in violation of the facility's zero tolerance policy against sexual abuse, assault, conduct or harassment will be offered therapy counseling or other interventions designed to address and correct the underlining reasons for their conduct.

There were no administrative or criminal findings of guilt for 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:

DYS Policy 9.18 PREA states that residents who disclose a history of sexual abuse or who disclose previously perpetrating sexual abuse, whether it occurred in an institutional setting or in the community, staff will ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. Medical staff interview verified compliance with this 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:

DYS Policy 9.18 PREA requires timely access to emergency medical treatment and crisis intervention services for victims of sexual abuse. There have been no victims of sexual abuse in the past 12 months; however, the nurse's interview verified that documentation would be included in the resident's medical record.

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:

DYS Policy 9.18 PREA requires ongoing medical and mental health care for sexual abuse victims. The policy also requires the facility to offer medical and mental health evaluations and appropriate follow-up treatment. Victims of sexual abuse will be transported to the Beacon Health Center where they will receive treatment and where physical evidence can be gathered by certified SAFE medical examiner. There have been no sexual assault victims in the past 12 months; however, if needed, procedures are in place as verified during medical staff interview.

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:

There have been no criminal or administrative investigations of sexual abuse in the past 12 months; however, DYS Policy 9.18 PREA requires a review of every sexual abuse allegation within 30 days of the conclusion of the investigation. The facility has a review form in place to document such review.

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:

DYS Policy 9.18 PREA requires the collection of accurate, uniform data for every allegation of sexual assault. The PREA Compliance Manager collects all data relating to PREA. DYS has a data collection instrument to answer all questions for the U.S. 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:

There have been no sexual abuse allegations within the past 12 months; however, DYS Policy 9.18 PREA 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)

X 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 PREA requires that data is collected and securely retained for 10 years. The aggregated sexual abuse data was 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.

Auditor **July 7, 2014**