PREA AUDIT: AUDITOR'S SUMMARY REPORT

Juvenile Facility

Name of facility: Langsford House				
Physical address: 525 Southeast Second Street; Lee Summit, MO 64063				
Date report submitted: August 7, 2014				
Auditor Information M P Wheeler & Associates (Mable P. Wheeler)				
Address: PO Box 5736 Macon, GA 31208				
Email: wheeler5p@hotmail.com				
Telephone number: 478-737-2171				
Date of facility visit: July 21, 2014				
Facility Information Langsford House				
Facility mailing address: same as above				
Telephone number: 816-622-0999				
The facility is:	☐ Military	☐ County	Federal	
	☐ Private for profit	☐ Municipal	☒State	
	☐ Private not for profit			
Facility Type:	☐ Juvenile	☒ Correction		
Name of PREA Compliance Manager: David Francis			**Title:** PREA Compliance Manager	Youth Facility Manager
Email address: david.francis@dss.mo.gov			**Telephone number:**	816-622-0999
Agency Information Division of Youth Services				
Name of agency: Division of Youth Services				
Governing authority or parent agency: *Department of Social Services*				

Physical address: 3418 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
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Agency-Wide PREA Coordinator		
Name: Judy Parrett	**Title:**	Assistant Deputy Director
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AUDIT FINDINGS

NARRATIVE: Langsford House in Lee's Summit, MO is a 12 bed male group home juvenile treatment facility operated by Division of Youth Services. The PREA Audit took place July 21, 2014 in Lee's Summit, MO. The facility has 1 group of male youth generally ranging in age from 12-17 years that have been adjudicated for less serious offenses, and this is often times their first out of home placement. They have been committed to the care and custody of the Division of Youth Services through the juvenile court system. The youth served are from the Northwest Region.

Langsford House employs 12 full time staff and 1 part time staff, whose efforts are enhanced by community partnerships and volunteers. Medical services are coordinated by a full time LPN under the guidance of a Regional Nurse and a contract physician is available to see residents as needed.

Treatment in the facility is multi-dimensional and includes individualized, educational, medical, and psychosocial, along with other needs and topics designated for the youth in care at the facility. Youth have the opportunity to complete community service projects and participate in a broad based curriculum that also includes outdoor based adventure activities. The facility environment is based upon maintaining safety, cleanliness, and organization at all times within a structured, positive, supportive environment. Treatment goals and objectives are based around the 5 Domains of well being which include Mastery, Stability, Safety, and Access to mainstream relevant resources, and social connections. Educational achievement is also an emphasis to assist youth in attaining academic skills to assist them in the future.

Therapeutic services are supplemented by a DYS Family Specialist, a licensed clinical Psychologist, and a psychiatrist on a referral basis. Families are encouraged to visit weekly and they are viewed as a vital role in a youth's treatment process.

DESCRIPTION OF FACILITY CHARACTERISTICS:

Langsford House is a ranch style home located in a residential neighborhood of Lee's Summit, MO. The layout of Langsford House is comprised of a living room, dining room, kitchen/pantry, classroom, laundry room, youth dorm/pod area, medical exam room, Manager's Office, and the Group Leader, Clerical and support staff shares an office area. Located in the backyard of the facility is a basketball court, garden, and shared yard area for youth to participate in recreational activity.

SUMMARY OF AUDIT FINDINGS:

The notification of the on-site audit was posted on June 9, 2014, six weeks prior to the first 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 housing unit and administrative areas.

The Pre-Audit Questionnaire, policies and supporting documentation were received. The documents, which were uploaded to a USB drive, were very well organized. The initial review revealed a need for additional documentation regarding volunteer training, and Youths ability to have unencumbered access to an outside agency for the purpose of reporting sexual abuse or sexual harassment.

The on-site audit was conducted July 21, 2014. After meeting with the facility's management staff and ODYS Central Office staff, a complete tour of the facility was conducted. During the tour, residents were observed to be under constant supervision of the staff while involved in various activities. The facility was clean and well maintained. There were no blind spots observed.

During the one day on-site visit, 7 on-site staff, 1 Central Office Staff and 5 youth were interviewed. Overall, the interviews revealed staffs are knowledgeable of PREA standards and were able to articulate their responsibilities. 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.

Number of standards exceeded**:** 0

Number of standards met: 40

Number of standards not met: 0

Not Applicable: 1

115.311 - Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

The following information was utilized to verify compliance with this standard:

Agency Policy #9.18 sec 1 relating to PREA ACT 0f 2003

Agency policy #3.8 sec 111 A.10 relating to employee misconduct

Agency policy #3.23 sec 111 A.1 relating to ethical standards (employees)

Agency policy #9.28 sec 111 E relating to developing relationships between staff and youth

The #9.18 policy guides staff in the implementation of the Prison Rape Elimination Act (PREA) at the Langsford House. It meets all requirements including definitions of prohibitive behaviors regarding sexual abuse and harassment. The policy designates a full-time statewide agency PREA Coordinator (Assistant Deputy Commissioner). This position oversees the agency's PREA Compliance Managers (Youth Facility Manager) at its facilities across the state. The PREA Compliance Manager reports to the Assistant Regional Administrator.

115.312 - Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

The following information was utilized to verify compliance with this standard:

Agency Policy #9.18 sec 111.A.1 Procedures

The policy has the necessary language to address the requirement of adding PREA language and ensuring that all contractors understand this requirement. There are 12 contracts for the confinement of juveniles. A review of these 12 contracts indicates compliance. Missouri DYS monitors all contracted facilities to monitor PREA.

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)

The following information was utilized to verify compliance with this standard:

Agency policy # 9.6 Program Supervision sec. IIIA1 Agency Policy 9.18 Sec. IIIA2

Agency policy #9.6 Program Supervision Sec. IIIA2

Agency policy # 9.6 Program Supervision Sec. IIIA3

DYS policy 9.6 mandates a 1:8 staff to resident ratio during wake hours and 1:16 staff to resident ratio during sleep hours. The staffing plan is based on the facilities rated capacity of 12 beds. The facility did not deviate from its staffing plan over the past 12 months. The annual review was documented as well as staff schedules for the past 12 months. Langsford House does not utilize video monitoring. Direct care staff provides residents with protection from sexual abuse and harassment. Facility Manager and PREA Coordinator conduct and document unannounced rounds on all shifts and all areas of the facility.

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)

The following information was utilized to verify compliance with this standard:

Agency policy # 5.8 Searches for Contraband Sec. IIIE

Agency policy # 5.8 Searches for Contraband Sec. III1c

Agency policy # 9.18 PREA Sec. IIIA3b

Agency Policy 9.6 Program Supervision Sec. III

Agency Policy 7.2 Standards Sec. IIID1e

There are no cross gender searches of residents by staff. Resident interviews also confirmed that staff respects their privacy during dressing, showering and normal bodily functions. Policy requires staff to respect the privacy of residents when showering, dressing and normal bodily functions. Policy requires staff of the opposite sex to announce their presence when entering housing units. Policy prohibits staff from conducting a search or physically examining a transgender or intersex resident. Youth interviews confirmed that staff of the opposite sex announced their entrance into the living areas.

115.316 – Residents with Disabilities and Inmates 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)

The following information was utilized to verify compliance with this standard:

Agency policy # 6.1 Programmatic Rights of Youth and Grievance Procedures Sec. IIIB

Agency policy # 8.3 Individual Education Program-Special Education Se. IIIB

Agency policy # 9.18 PREA Section IIIA4b

There have been 0 instances where the services of an interpreter was needed during the last 12 months.DYS has contracts with interpreters or other professionals to ensure effective communication with residents with disabilities and residents who are limited English proficient. At no time are other residents allowed to serve as interpreters. Resident interviews verified the facility does not use resident assistants and there were no instances of resident interpreter or readers being used in the past 12 months.

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)

The following information was used in determining compliance with the Hiring and Promotion of staff:

Agency policy # 9.18 PREA Sec. IIIA5

Agency policy # 9.18 PREA Section IIIA5d and e DSS Policy 2-107 Section: Background Checks on Current Employees pg.2 DSS Policy 2-107 Background Checks p.4

Agency Policy 9.18 PRES Section IIIA5g

During the past year 16 new employees were hired and background checks were completed on all applicants. A review of staff files revealed that all new hires had documented criminal background checks. The 1 contract for, a service provider, who has contact with residents, had documented criminal background checks. DYS policy 9.18 provides for annual background checks on all employees.

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)

The following information was utilized to verify compliance with this standard:

Langsford House does not utilize a video monitoring system, electronic surveillance system or other monitoring technology. There are no proposed upgrades to facility.

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)

The following information was used to verify compliance with this standard:

Agency policy # 9.18 PREA Section III.1.2 d

Agency policy # 9.18 PREA Section III1 (d)

Agency policy # 9.18 PREA Section IIIB1 (d)

The Missouri Division of Youth Services does not conduct its own investigation of sexual abuse or harassment. Investigations are conducted by Missouri Children's Division Out of Home Investigation Unit for DYS for youth under the age of 18. They receive reports through their hot line number made by DYS staff, the youth, parent, guardian or external entity on behalf of the youth. If law enforcement is not already involved, CD-

OHI contacts the appropriate law enforcement agency to co-investigate. Allegations of sexual abuse of those youth 18 and over are referred to the Division of Legal Services Investigation Unit. All forensics are completed by a local hospital. The hospital is a part of a network of Safe-Care medical providers. This service is provided at no cost to residents as outlined by policy. There have been no forensic examinations in the last 12 months. Victim Advocates agencies are willing to provide services but none has agreed to sign a MOU. The auditor viewed documentation of attempts to secure an MOU with an advocacy agency. There are also qualified staff members at the facility that can provide crisis intervention if requested by the resident in addition to outside providers.

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)

The following information was used to determine compliance with this standard:

Agency policy # 9.18 Section IIIB2

Agency policy # 3.8 Section IIIC2d

Agency policy #6.1 Section IIIP

Agency policy # 9.18 PREA Section IIIB1a

The agency has published its 2013 Annual Report and this was examined prior to arriving at the facility. The statewide PREA Coordinator was also interviewed and discussed this report. During the last 12 months there have been 0 allegations of sexual abuse and sexual harassment at this facility. The agency did not have a report of sexual abuse against a youth by another youth during the calendar year 2013.

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)

The following information was used to determine compliance with this standard:

Agency policy #9.18 sec III. C PREA training series.

Training curriculum slide 61 relates to Agency's zero-tolerance for sexual abuse and sexual harassment.

Training curriculum slides 64-70 relates to how the agency fulfills their responsibilities under agency sexual abuse and harassment prevention, detection, reporting and response policies and procedures.

Training curriculum slide 7 addresses residents' right to be free from sexual abuse and harassment.

Training curriculum slide 7 relates to the right of residents and employees to be free from retaliation for reporting sexual abuse/harassment.

Training curriculum slides 16-26 –the dynamics of sexual abuse/harassment in juvenile facilities.

Training curriculum slides 20-22 address the common reactions of sexual abuse/harassment of juvenile victims.

Training curriculum 64-70, 7-how to detect and respond to signs of threatened and actual sexual abuse.

Training curriculum slides 55-56 addresses how to avoid inappropriate relationships with residents.

How to communicate effectively and professionally with residents, including lesbian, gay, bisexual transgender, intersex, or gender nonconforming residents-Training curriculum slides 52-53.

Training Curriculum slides 5-7 relates to how to comply with laws related to mandatory reporting of sexual abuse to outside authorities.

Training curriculum slide 63 is relevant to the laws regarding the applicable age of consent.

DYS policy 9.18, the training curriculum, staff training records and staff interviews revealed staff receives PREA training during initial training and annually during refresher training. Employee training rosters were verified. All employees are trained as new hires regardless of their previous experience.

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)

The following information was used to verify compliance with the standard.

Agency Policy# 9.18 and Fundamental Practices

In the last 12 months 1 volunteer or contractor was trained in the agency's policies and procedures regarding sexual abuse and harassment. Every volunteer and contractor signed acknowledgement forms indicating receiving this training. All trainees were trained in the agency's Zero Tolerance Policy. All managers have been advised of the addition of a cover letter to the DYS Fundamental Practices.

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)

The following information was utilized to verify compliance with this standard:

Agency Policy #9.5 Sec III.B1d

In the past 12 months 20 new admissions received information immediately after admission regarding the facility's zero tolerance policy and how to report sexual abuse and harassment. Residents are provided a handout entitled "Safety 1st". Documentation of residents 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.

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)

The following information was utilized to verify compliance with this standard:

DYS does not conduct administrative or criminal investigations: however, documentation was reviewed indicating that PREA requirements for specialized training for investigators who investigate allegations of sexual abuse and sexual harassment in confinement were provided to CE-OHI and DLS.

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)

The following information was utilized to verify compliance with this standard:

Agency policy #9.18 PREA Section IIIC (a)

Agency policy #3.18 Training Section IIIJ

DYS policy 3.18 requires PREA training and specialized training for medical staff. A certificate documenting the nurse's participation in specialized training offered on-line by NIC was provided and verified during an interview with the nurse. The nurse does not conduct forensic examinations.

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)

The following information was utilized to verify compliance with this standard:

For screening upon admission the following policies are in place;

Agency Policy 9.5 Res. Care sec IIIA-B

Agency Policy 9.18 PREA section IIID1b

Agency Policy 9.5 Res. Care sec IIIB1a

Agency Policy 9.18 PREA Section IIID2e

Agency Policy 6.7 Section I

During the last 12 months 20 youth have been screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their entry into the facility. The policy limits staff access to this information on a "need to know basis". Staff has initiated asking youth whether they identify with being gay, bi-sexual, transgender or intersex. In order to insure consistent and therapeutic treatment of all youth in the division and in accordance with RSMo 219.021(5), the agency will conduct administrative case reviews on each youth every six (6) months.

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)

The following information was utilized to verify compliance with this standard:

Agency Policy 9.18 PREA Sect. IIID2a

Agency Policy 9.8 Separation section IIIA

Agency Policy 9.18 PREA Sec. IIID2d

Agency Policy 9.8 Separation Sec. B7 (a-j)

Agency Policy 9.18 SecIIID2a

Agency Policy 6.1 Section IIID

Agency Policy 9.28 Section IIIC

Agency Policy 9.8 Sec. IIIB6

There have been no residents placed in isolation in the last 12 months because of victimization. Agency policies prohibit placing gay, bisexual, transgender, or intersex residents into confinement based solely on such identification or status. Housing and program assignment policies require determinations on each transgendered or intersex on a case by case basis. A policy exists that requires a reassessment every 30 days of any gay, bisexual, transgender, or intersex resident. In the last 12 months there were no residents who fit into any of these categories at this facility according to interviews with medical staff and the superintendent.

115.351 – Inmate 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)

The following information was utilized to verify compliance with this standard:

Agency policy # 9.18 PREA Section IIIE1 the agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials.

Agency policy# 6.1 Programmatic Rights Section IIIP and V

Agency policy 5.12 Establishment and maintenance of Manuals Section IIIA14a Youth/Parent Handbook

Agency policy 9.18 PREA Section IIIE1b The agency has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing anonymously and from third parties.

Agency policy 9.18 PREA Section IIIF1

Agency policy 3.8 Employee Conduct Section IIIC2

DSS policy 2-101 Sexual/Harassment/Inappropriate Conduct pp 3-4 RSMO 210.115.1 The agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents.

Agency policies dictate multi-ways for residents to report sexual abuse and harassment including a Child Abuse and neglect hotline to an outside agency. They may report to any staff or family member. Various ways for staff to privately report are also outlined in the policy. Resident interviews verify that youth advise staff of the need to utilize hotline and access is permitted. Staff do not question youth regarding request.

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)

The following information was utilized to verify compliance with this standard:

Agency does have administrative procedures to address resident grievances regarding sexual abuse. Residents may put a written complaint in the designated PREA box in their living area. 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.

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)

The following information was utilized to verify compliance with this standard:

Agency policy # 9.18 PREA Section IIIE3a the facility provides access to outside victim advocates for emotional support services related sexual abuse.

Agency policy #6.2 Legal representation, the facility provides residents with reasonable and confidential access to their attorneys or other legal representation

Agency policy #.6.5 youth's visit, mail and telephone

Agency policy # 9.18 Section III3d

Documentation provided by facility to support attempts to establish an MOU with a local victim advocate agency. The agency has agreed to provide services but unwilling at this time to enter into an MOU.

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)

The following information was utilized to verify compliance with this standard:

Web link to DYS page that allows for the public to report resident sexual abuse or harassment through the Children's Division Hotline or for other complaints or youth age 18 and over, they can send a complaint through the 'asked DYS' link: http://dss.mo.gov/dys/

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)

The following information was utilized to verify compliance with this standard:

Agency policy # 3.8 Employee Conduct Section IIIC

Agency policy # 2-101 Sexual Harassment/Inappropriate conduct pp.3

Agency policy # 9.18 PREA Section IIIF2

All Langsford House 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.

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)

The following information was utilized to verify compliance with this standard:

Agency policy 9.18 PREA Section IIIF3

When the agency or facility learns that a resident is subject to substantial risk of imminent sexual abuse, it takes immediate action to protect resident.

There have been no incidents in the last 12 months where the agency took any action in regards to a resident being in substantial risk of imminent sexual abuse. Policy guides the agency's responses if it becomes necessary.

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)

The following information was utilized to verify compliance with this standard:

Agency policy 9.18 PREA Section IIIF5

Agency policy 3.8 Employee Conduct Section IIIC2

Agency policy 3.8 Employee Conduct Section IIIC

There have been no reports from other facilities related to sexual abuse or harassment of a resident placed at Langsford House. Agency policy serves as the guide should the event ever occur. Documentation of a report would give cause for notification to Missouri Division of Home Investigation Unit.

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)

The following information was utilized to verify compliance with this standard:

Agency policy # 5.12 Section III.A.14.K

The auditor viewed the agency protocol for "staff first responder duties". All areas were covered to include duties for security and non-security staff members. There have been 0 allegations that a resident was sexually abused within the last 12 months. Random staff interviews revealed considerable knowledge of actions to be taken upon learning that a resident was sexually abused.

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)

The following information was utilized to verify compliance with this standard:

Facility Institutional Plan

Auditor viewed institutional plan developed to coordinate actions taken in response to an incident of sexual abuse among staff, first responders and other departments. Staff interviews and interviews with the Facility Manager indicate that staffs are aware of their responsibilities to coordinate responses within the facility.

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)

The following information was utilized to verify compliance with this standard:

The current labor agreement resolution is dated 12/1/2010 -11/30/2013. Documentation states 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 PREA standards 115.372 and 115.376.

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)

The following information was utilized to verify compliance with this standard:

Agency policy 9.18 PREA Section IIIE6

Agency policy 2-101 Sexual Harassment/Inappropriate Conduct pg.1

The Facility Manager is responsible for monitoring retaliation. Additional administrative staff is charged with the responsibility of monitoring retaliation. If the conduct was identified the monitoring would be conducted no less than 90 days, longer if necessary. There have been 0 incidents within the last 12 months.

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)

The following information was utilized to verify compliance with this standard:

Agency policy #9.18 PREA Section IIID2d

Agency policy #9.8 Separation Section IIIB6

Facility does not have an isolation room. There has been 0 youth alleging to be victims of sexual abuse during the last 12 months.

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)

The following information was utilized to verify compliance with this standard:

Agency policy # 9.18 PREA Section IIIG1

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 appear to be criminal are referred for prosecution.

115.372 – Evidentiary Standard for Administrative Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

The following information was utilized when verifying compliance with this standard:

The Missouri Child Welfare Manual (section 2, chapter 4) states a standard of preponderance of evidence or lower standards of proof are used for determining if allegations are substantiated.

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)

The following information was utilized when verifying compliance with this standard:

Agency policy # 9.18 PREA Section IIIG2a

Agency policy # 9.18 PREA Section IIIG2b

Agency policy #9.18 PREA Section IIIG2c 1-2

Agency policy # 9.18 PREA Section III2d

There have been 0 notifications to residents that were made pursuant to this standard within the last 12 months. All elements of the standard are found in the above identified policies.

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)

The following information was utilized to verify compliance with this standard:

Agency policy # 9.18 PREA Section IIIH

Agency policy 2-124 Discipline pg.7

Agency policy 2-101 Sexual Harassment/Inappropriate Conduct pg.1

There has been no staff that has violated agency sexual abuse or harassment policies. There had been no substantiated allegations at the facility within the last 12 months. Agency policies would be followed if the need arise. Staff would be subjected to disciplinary sanctions up to and including termination.

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)

The following information was utilized to verify compliance with this standard:

Agency policy # 9.18 PREA Section IIIH1b

There have been no contractors or volunteers accused of any PREA violations in the last 12 months, therefore there have been no sanctions. 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.

The policy also requires the facility staff to take remedial measures and prohibit future contact with resident 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.

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)

The following information was utilized to verify compliance with this standard:

Agency policy # 9.18 PREA Section IIIH3

There has been no resident on resident sexual abuse therefore there are no instances to review. The Facility Manager was interviewed and indicated the policies would be followed if such an event occurred. 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.

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)

The following information was utilized to verify compliance with this standard:

Agency policy # 9.18 PREA Section III(1)a

Agency policy 7.2 Standards Section IIIA

The vulnerability review form is utilized to screen all new intakes. All residents who disclose any prior sexual victimization are offered a follow-up meeting with a medical or mental health practioner. Youth 18 or over must sign a consent form before allegations of abuse are reported. In the past 12 months, 100% of youth who disclosed prior victimization during screening were offered a follow up meeting with a mental health practioner.

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)

The following information was utilized to verify compliance with this standard:

Agency policy # 9.18 PREA section III (1)2c-d Treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

The auditor reviewed directives to staff regarding the documentation and review for timeliness of emergency medical treatment and crisis intervention services. Auditor also reviewed copy of critical incident report.

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)

The following information was utilized to verify compliance with this standard:

Agency policy 9.18 Section III (1) 3

Agency policy 6.1 Programmatic rights of Youth and the Grievance Process section III G

Agency policy 7.2 Standards Section IIIA3

Agency policy 7.3 Special Needs

Agency policy 7.4 Access to Medical

The facility shall offer medical and mental health evaluations and appropriate treatment in adherence to PREA standards. Care is consistent with the community level of care. There have been no sexual assault victims in the past 12 months; however, if needed, procedures are in place as verified during medical staff interviews.

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

☐ Does Not Meet Standard (requires corrective action)

The following information was utilized to verify compliance with this standard:

Agency policy # 9.18 sec.III.J.1.a

Agency policy #9.17 sec III.E

There have not been any criminal investigations conducted in the last 12 months. The before mentioned policies would guide staff through review process.

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)

The following information was utilized to verify compliance with this standard:

Agency policy # 9.18 sec III.J.2.a

Policy 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 US Department of Justice Survey of Sexual Abuse Violence. A review of the annual report revealed it was completed according to this 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)

The following information was utilized to verify compliance with this standard:

Agency Policy #9.18 Sec III J.1.a

DYS Annual report reveals 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.

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)

The following information was utilized to verify compliance with this standard:

Agency policy #9.18 Sec. III J.2.f

DYS Policy 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 his/her knowledge and no conflict of interest exists with respect to his or her ability to conduct an audit of the agency under review.

Auditor Signature Date