PREA AUDIT REPORT ☐ INTERIM ■ FINAL

JUVENILE FACILITIES

Auditor Information				
Auditor name: Kevin Maurer				
Address: P.O. Box 408, Deerfield Beach, FL 33442				
Email: kevin.maurer@us.g4s.com				
Telephone number: 954-790-3735				
Date of facility visit: 06/09/2015				
Facility Information				
Facility name: Spanish Lake Cottage				
Facility physical address: 13312 Bellefontaine Rd, St. Louis, MO 63138				
Facility mailing address: *(if different from above)*				
Facility telephone number: 314-355-2642				
The facility is:	☐ Federal	■ State	☐ County	
	☐ Military	☐ Municipal	☐ Private for profit	
	☐ Private not for profit			
Facility type:	■ Correctional	☐ Detention	☐ Other	
Name of facility's Chief Executive Officer: Arthur Trass				
Number of staff assigned to the facility in the last 12 months: 26				
Designed facility capacity: 24				
Current population of facility: 24				
Facility security levels/inmate custody levels: Moderate (Medium Security)				
Age range of the population: 14 - 17				
Name of PREA Compliance Manager: Arthur Trass		**Title:**	Facility Manager	
Email address: arthur.trass@dss.mo.gov		**Telephone number:**	314-355-2642	
Agency Information				
Name of agency: Division of Youth Services				
Governing authority or parent agency: *(if applicable)* Department of Social Services				
Physical address: 3418 Knipp Drive, Jefferson City, MO 65102				
Mailing address: *(if different from above)*				
Telephone number: 573-751-3324				
Agency Chief Executive Officer				
Name: Phyllis Becker		**Title:**	Int. Div. Director	
Email address: phyllis.becker@dss.mo.gov		**Telephone number:**	573-751-3324	
Agency-Wide PREA Coordinator				
Name: Judy Parrett		**Title:**	Asst. Dpty. Director	
Email address: judy.parrett@dss.mo.gov		**Telephone number:**	573-751-3324	

AUDIT FINDINGS

NARRATIVE

Spanish Lake was audited on June 8 - 10, 2015 by DOJ PREA Auditor Kevin Maurer. Prior to the on-site audit, a review of all pre-audit documents was completed. During the initial audit meeting, Audry Helfrich, Assistant Regional Administrator, Carlos Newberry, Assistant Regional Administrator, and Arthur Trass, Youth Facility Manager, were present. A facility tour was conducted, which included all buildings, rooms, and grounds of the program's facility. During the tour, it was noted that the Notice of PREA Audit and other PREA related materials were posted in several locations.

Interviewees were identified from a list of staff and residents. The interviewees included 10 residents and 8 random staff. Additionally, 7 Specialized Staff interviews were completed. In the past 12 months, there was one reported allegation of sexual abuse, which was found to be unsubstantiated. Additionally, there are no residents who identified with being LGBTI.

It should be noted that the staff of Division of Youth Services (DYS) and Spanish Lake were very well prepared and organized for the on-site audit, and all pre-audit materials were in order and well highlighted. This shows the dedication and concern for the PREA program from both an agency as well as a program level.

DESCRIPTION OF FACILITY CHARACTERISTICS

Spanish Lake Cottage is a 24 bed moderate secure boys treatment facility located in St. Louis, MO on the Missouri Hills Campus. The facility is composed of two groups, 12 boys per group, that have been determined to be at risk youth. The youths have been committed to the care and custody of the Division of Youth Services through the juvenile court system. Spanish lake serves youth from St. Louis County and the City of St. Louis. Generally, youth are committed to this facility for offenses ranging from felonious assault to substance abuse to unlawful sexual offenses.

Treatment in the facility is varied and includes individualized, group, educational, medical, and psychosocial, along with other needs and topics specialized and individualized to meet the needs of each youth in care at Spanish Lake. Youth meeting and exceeding program expectations participate in many community activities such as Cardinals baseball games, the campus work program , where they earn wages and learn valuable workplace skills, and adventure based counseling opportunities.

The facility environment is based upon maintaining safety, cleanliness, and organization at all times within a structured, positive, and supportive environment. Treatment goals and objectives are developed in the context of youth and family strengths and assets, are trauma informed, incorporate positive youth development principles within the framework of well-being including mastery, stability, safety, access to mainstream relevant resources, and social connections.

SUMMARY OF AUDIT FINDINGS

On June 8 - 10, 2015, Spanish Lake had its on-site PREA Audit completed. The results of the audit indicate that the facility is in full compliance with PREA Standards, and a final report is being issued.

Number of standards exceeded: 7

Number of standards met: 26

Number of standards not met: 0

Number of standards not applicable: 8

Standard 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)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

DYS Policy 9.18 addresses zero tolerance toward all forms of sexual abuse and sexual harassment in the facility. The policy outlines how the facility will prevent, detect and respond to sexual abuse and sexual harassment. The definitions of prohibited behaviors are clearly defined, as are the sanctions for those who violate the policy.

The agency has designated the Assistant Deputy Director, Judy Parrett, as the PREA Coordinator. She is very knowledgeable of the PREA requirements, devotes sufficient time and effort in assisting facility staff with PREA-related issues, and has the authority to implement corrective actions. The Facility Manager, Arthur Trass, is the PREA Compliance Manager for the facility and stated that he has sufficient time and authority to coordinate the facility's compliance with the PREA standards.

Standard 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)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

N/A - Spanish Lake does not contract with other entities for the confinement of residents.

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)

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DYS Policy 9.6 outlines supervision and monitoring at the facility. It states that DYS shall ensure that its residential staffing and monitoring plans meets the requirements established in the PREA standard 115.313 which states that the facility shall maintain staff ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances, which shall be fully documented. Spanish Lake maintains a waking hours ratio of 1:6 and a sleeping hours ratio of 1:12. The facility has initiated the practice of unannounced rounds with documentation in place. Interviews with staff confirm that unannounced rounds take place.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Spanish Lake allows for pat-down searches in exigent circumstances only. The facility does not conduct cross-gender strip searches, visual body cavity searches, or pat-down searches, even in exigent circumstances. DYS Policy 5.08 prohibits searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. This was confirmed during staff and youth interviews.

All toilets have doors, and all showers have double curtains. Male and female staff are subject to supervise in the dorm bathroom/shower areas. The staff do not view the youth unclothed but are able to see feet and heads and are required to remain in bathroom area providing awareness supervision. Both review of policies and interviews with staff and youth confirmed that staff do not view the youth unclothed. Female staff announce their presence when entering the dorm building. This was confirmed during staff and resident interviews.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

DYS Policy 9.18 prohibits the use of resident translators, resident readers, or other types of resident assistants. This was confirmed by interviews with staff. Spanish Lake utilizes a telephone interpreter service, as well as has resident PREA education materials available in Spanish.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

DYS Policy 9.18 addresses all elements of standard 115.317. The agency conducts extensive background checks and reference checks with multiple entities upon offer of employment. Background checks are conducted annually.

Standard 115.318 Upgrades to facilities and technologies

- ☐ 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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

N/A - Spanish Lake has not had any facility or technology upgrades.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

N/A - Spanish Lake does not conduct administrative or criminal investigations. Investigations are conducted by Missouri Children's Division (OHI – Out of Home Investigations) and the St. Louis County Police Department. These elements of the standard are N/A.

Forensic medical exams, when needed, are conducted at Northeast Christian Hospital in St. Louis, MO at no cost to the resident.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

DYS Policy 9.18 ensures that an administrative/criminal investigation is completed, as required. Division of Youth Services requires that all allegations be reported to the Missouri Children's Division, (O.H.I.) for investigation. Allegations that are criminal in nature are reported to the St. Louis County Police Department. There was one PREA-related allegations made at Spanish Lake the previous 12 months, which was found to be unsubstantiated.

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)

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All Spanish Lake staff have completed both facility and Missouri Children's Division PREA Training, which covers all topics outlines in standard 115.331 and as mandated by DYS Policies 9.18 and 3.18. Refresher training is provided to the staff and they also are required to review and sign the PREA Acknowledgment and Notification form. Staff interviews confirm this practice.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Spanish Lake uses volunteers and contractors. Documentation shows that all volunteers and contractors have completed PREA training, which is the same as the staff are required to complete.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Initial education is provided to the residents during the intake admission process. They are provided the "Safety First Packet" as well as a workbook that they complete answering questions about PREA information in the packet. Residents are also provided a PREA pamphlet which is available in English or Spanish. Additional written material is provided that describes the resident's right to be safe from sexual violence and information on the various ways they can report an allegation of sexual abuse or harassment or receive services. If the resident has limited reading skills, intake staff will read the written materials to them.

This PREA related information is reviewed in greater detail during group and individual counseling sessions shortly after they arrive at the facility.

Posters with the phone number for the PREA Hotline are displayed in the Administrative/Educational Building and Dorm buildings.

Interviews with residents confirmed that they understand the PREA education they received and the various ways to report a PREA related incident.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

N/A - Spanish Lake does not conduct investigations

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Medical staff received Medical Professionals training provided through the NIC and the State of Missouri. Spanish Lake does not conduct forensic medical exams. Medical staff receive the same training as security staff.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The facility utilizes an Assessment, Checklist and Protocol for Behavior and Risk for Victimization assessment and screening instrument, which meets all the requirements of PREA standards. The screening is conducted for all residents admitted to the facility within 72 hours of intake, and usually within 24 hours. The screening consists of resident interview questions and staff review of classification information. All of the resident files checked were completed within 24 hours. The residents are re-assessed every six months, unless the resident makes an allegation of sexual abuse or harassment, in which case the re-assessment is done immediately.

DYS Policy 9.18 addresses the control and dissemination of information gathered from the screening to be on a "need to know" basis.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The current housing classification system is based primarily on availability. Screening, assessment, and classification information gathered during the intake process is used to place residents in an area of the dorm that best ensures each resident's safety and security. Education and treatment are conducted in both the Educational Building and Dorm building. Spanish Lake does not have any form of isolation.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Spanish Lake provides multiple internal and external ways for residents to privately report sexual abuse, harassment and retaliation by residents or staff. All residents identified the reporting numbers for the state agencies listed on the posters in the facility, as well as stated that they can confide in a staff member, tell a family member, or tell their Service Coordinator. Residents also confirmed that they have access to writing materials, both during the school day, as well as in the housing areas.

Interviews with staff confirmed that they accept and document all reports, whether verbal or written, and from any source. The interviews also confirmed that staff can privately report sexual abuse or harassment of residents, using the Children's Division Hotline.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

N/A - Although there is a grievance procedure available for residents, policy dictates that PREA allegations are not officially utilized by residents in this capacity.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Spanish Lake currently has a documented attempt with the Children's Advocacy Services of Greater St. Louis (CASGSL) to provide victim advocate and supportive services to residents upon request. Posters containing the Children's Division, (O.H.I.) hotline number are prominently posted in both the Educational Building and Dorm building. Interviews with residents confirmed that they are aware of these posters and their right to call and make reports. Each resident has a primary Service Coordinator who can access outside support services upon request of the resident.

Staff and resident interviews confirmed that staff provide youth with the limitations of confidentiality, regarding mandatory reporting laws. Interviews with residents confirmed that those residents who currently have attorneys can communicate with them confidentially. None had reported being denied access to their attorneys. All residents also reported that they have family visitation and phone calls, and that they have never been denied access to their families.

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)

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Spanish Lake uses the Children's Division, (O.H.I.), Hotline for third-party reporting, and informs parents and guardians in writing that they may call this number to make a report.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

All staff are mandated child abuse reporters and receive appropriate training. DYS Policy 3.8 policy requires all staff to report any PREA related incident or retaliation against youth or staff who made a report. Policy strictly prohibits the disclosure of information related to a report of sexual abuse, except on an "as needed" basis in order to make treatment and related decision.

Interviews with medical staff confirmed that they are mandated child abuse reporters and that they inform youth of their duty to report and the 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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Although there were no instances during the previous 12 months where a youth was subject to substantial risk of imminent sexual abuse, staff interviews confirmed that staff have received training as to how to immediately protect a youth by separating the youth and alleged perpetrator, notifying their supervisor, and completing an incident report. All staff expressed that their primary responsibility at all times is the safety of youth in the facility.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

FDYS Policy 9.18 requires prompt notification, documentation and follow-up with the prior facility. Missouri law also requires mandated reporters to report such an allegation to the Children's Division, (O.H.I.), Hotline.

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)

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DYS Policy 9.18 addresses the requirements of standard 115.364. Interviews with staff confirmed that they have received first responder training and were able articulate the steps they are to take when responding to an incident of sexual abuse.

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)

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Spanish Lake has a detailed, facility specific coordinated response plan that also includes a First Responder protocol and a First Responder Check List that ensures the highest level of coordination among the responding staff.

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)

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Missouri DSS has a Labor Agreement with the Communication Workers of America that outlines the requirements of standard 115.366

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

DYS Policy 9.18 protects all youth and staff from retaliation. This policy includes protective measures, follow up, and periodic status checks, as required by standard 115.367. Although there have been no incidents of retaliation in the past 12 months, interviews with staff responsible for taking protection measures were able to articulate the requirements of the policy.

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)

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N/A - The facility does not utilize any form of segregated housing.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

N/A - The facility does not conduct any administrative or criminal investigations.

Standard 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)

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N/A - The facility does not conduct any administrative or criminal investigations.

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)

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DYS Policy 9.18 requires the Program Director or designee to inform the resident who made the allegation of the outcome, as required by the standard, unless the allegation is unfounded.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

There were no staff violations of facility sexual abuse or sexual harassment policies the previous 12 months. DYS Policy 9.18 identifies the requirements of standard 115.376

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

There were no contractor or volunteer violations of facility sexual abuse or sexual harassment policies the previous 12 months. DYS Policy 9.18 identifies the requirements of standard 115.377

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the 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. It is possible that when a resident on resident sexual assault is substantiated, the perpetrator may be moved to a different facility. This may not involve a return to the juvenile court system, and therefore would not be a requirement to register as a sex offender. If new criminal charges were filed by the Juvenile Court for that county, the court would determine the requirement to register as a sex offender.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

DYS Policy 9.18 complies with all elements of standard 115.381. Interviews with medical staff confirmed that services would be provided, if requested by a resident. The policy strictly controls the dissemination of information related to sexual victimization or abusiveness of resident on an as "need to know" basis.

Interviews with residents confirmed that youth are informed of the limits of mandatory child abuse reporting and confidentiality.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

DYS Policy 9.18 and contract requirements require access to unconditional, immediate emergency medical and mental health services at no cost to the resident or family, not only for resident victims of sexual abuse, but for all youth in the facility, whenever they need it. Although there were no resident victims of sexual abuse during the prior 12 months, facility policy requires that the resident victim be provided with information regarding STD prophylaxis. Medical staff reported that this would also be provided at the hospital.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Although there were no resident victims of sexual abuse at Spanish Lake during the prior 12 months, DYS Policy 9.18 requires any resident victim be provided with ongoing medical and mental health services that are needed.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

There was one PREA related resident on resident allegations made in the previous 12 months at Spanish Lake, which was found to be unsubstantiated. A review was conducted of the alleged incident as outlined by standard 115.386. All elements of standard 115.386 are met within DYS Policy 9.18.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

DYS collects, aggregates, and maintains the data, as required by standard 115.387. The data instrument collects the data necessary to answer all questions from the USDOJ Survey of Sexual Violence.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

DYS has conducted its annual review under standard 115.388 for 2014 data. The 2012 - 2014 data is available to the public on the DYS website.

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 discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

DYS meets the requirements of standard 115.389 through the DYS website, where the public may access the agency's data reports and corrective actions.

AUDITOR CERTIFICATION

I certify that:

- ■ The contents of this report are accurate to the best of my knowledge.
- ■ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- ■ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Kevin M. Maurer — 07/07/2015

Auditor Signature — Date