Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Interim Audit Report: Click or tap here to enter text. ☐ **N/A**
If no Interim Audit Report, select N/A
Date of Final Audit Report: 5/22/2021

Auditor Information			
Name: Latera M. Davis		**Email:** laterad@yahoo.com	
Company Name: Just4Consutlants, LLC			
Mailing Address: PO Box 1105		**City, State, Zip:** Grayson, GA, 30017	
Telephone: 404-457-8953		**Date of Facility Visit:** 4/6-4/8/2021	
Agency Information			
Name of Agency: Missouri Division of Youth Services			
Governing Authority or Parent Agency *(If Applicable):* Department of Social Services			
Address: 3418 Knipp Dr. Ste. A-1		**City, State, Zip:** Jefferson City, MO 65109	
Mailing Address: 3418 Knipp Dr. Ste. A-1		**City, State, Zip:** Jefferson City, MO 65109	
The Agency Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☒ State	☐ Federal
Agency Website with PREA Information: https://dss.mo.gov/reports/prison-rape-elimination-act-reports/			
Agency Chief Executive Officer			
Name: Scott Odum			
Email: scott.odum@dssmo.gov		**Telephone:** 573-751-3324	
Agency-Wide PREA Coordinator			
Name: Jennifer Hanes/Judy Parrett			
Email: Jennifer.hanes@dss.mo.gov; judy.parrett@dss.mo.gov		**Telephone:** 573-751-3324	
PREA Coordinator Reports to: Scott Odum		**Number of Compliance managers who report to the PREA Coordinator:** 21	

Facility Information			
Name of Facility: Ft. Bellefontaine Campus			
Physical Address: 13298 Bellefontaine Road		**City, State, Zip:** St. Louis, MO 63138-1603	
Mailing Address: SAA		**City, State, Zip:** SAA	
The Facility Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☒ State	☐ Federal
Facility Website with PREA Information: Division of Youth Services Prison Rape Elimination Act Compliance Annual Reports t | Missouri Department of Social Services (mo.gov)			
Has the facility been accredited within the past 3 years? ☐ Yes ☒ No			
If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years): ☐ ACA ☐ NCCHC ☐ CALEA ☐ Other (please name or describe: Click or tap here to enter text. ☒ N/A			
If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe: USDA; DFAS (financial audit)			
Facility Administrator/Superintendent/Director			
Name: Jacqueline Twitty			
Email: jacqueline.twitty@dss.mo.gov		**Telephone:** 314-355-8088	
Facility PREA Compliance manager			
Name: Jacqueline Twitty			
Email: jacqueline.twitty@dss.mo.gov		**Telephone:** 314-355-8088	
Facility Health Service Administrator ☐ N/A			
Name: Regina Parish			
Email: regina.l.parish@dss.mo.gov		**Telephone:** 314-355-8088	
Facility Characteristics			

Designated Facility Capacity:	24
Current Population of Facility:	18
Average daily population for the past 12 months:	16
Has the facility been over capacity at any point in the past 12 months?	☐ Yes ☒ No
Which population(s) does the facility hold?	☐ Females ☒ Males ☐ Both Females and Males
Age range of population:	13-17
Average length of stay or time under supervision	138 days
Facility security levels/resident custody levels	Moderate (Medium)

Number of residents admitted to facility during the past 12 months	32
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:	27
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *10 days or more:*	25
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	☐ Yes ☒ No
Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	☐ Federal Bureau of Prisons ☐ U.S. Marshals Service ☐ U.S. Immigration and Customs Enforcement ☐ Bureau of Indian Affairs ☐ U.S. Military branch ☐ State or Territorial correctional agency ☐ County correctional or detention agency ☐ Judicial district correctional or detention facility ☐ City or municipal correctional or detention facility (e.g. police lockup or city jail) ☐ Private corrections or detention provider ☐ Other - please name or describe: Click or tap here to enter text. ☒ N/A
Number of staff currently employed by the facility who may have contact with residents:	19
Number of staff hired by the facility during the past 12 months who may have contact with residents:	2
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	7 (OA Maintenance)
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	7

Number of volunteers who have contact with residents, currently authorized to enter the facility:	0
Physical Plant	
Number of buildings: **Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.**	1
Number of resident housing units: **Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.**	2
Number of single resident cells, rooms, or other enclosures:	0
Number of multiple occupancy cells, rooms, or other enclosures:	0
Number of open bay/dorm housing units:	2

Number of segregation or isolation cells or rooms (for example, administrative, disciplinary, protective custody, etc.):	0
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	☐ Yes ☒ No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	☐ Yes ☒ No

Medical and Mental Health Services and Forensic Medical Exams	
Are medical services provided on-site?	☐ Yes ☒ No
Are mental health services provided on-site?	☐ Yes ☒ No
Where are sexual assault forensic medical exams provided? Select all that apply.	☐ On-site ☐ Local hospital/clinic ☐ Rape Crisis Center ☒ Other (please name or describe: Children's Advocacy Services of Greater St. Louis))

Investigations	
Criminal Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:	0
When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.	☐ Facility investigators ☐ Agency investigators ☒ An external investigative entity
Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)	☐ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☒ Other (please name or describe: Division of Out of Home Investigations: Division of Legal Services)) ☐ N/A
Administrative Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	0

When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: *Select all that apply*	☐ Facility investigators ☐ Agency investigators ☒ An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	☐ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☒ Other (please name or describe: (Division of Out of Home Investigations: Division of Legal Services) ☐ N/A

Audit Findings

Audit Narrative (including Audit Methodology)

The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-onsite audit, onsite audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.

Ft. Bellefontaine, is a facility operated by the Missouri Division of Youth Services agreed to participate in a Prison Rape Elimination Act (PREA) audit, conducted by auditor (Latera Davis) and associate (Debaja Coleman).

Site Review Location: The site review for this audit took place at the Missouri Hills Campus located at 13290 Bellefontaine Road, St. Louis, MO 63138-1607. The facility is located in the St. Louis area. The auditor conducted pre-audit work prior to arrival at the facility. Pre-audit work included but was not limited to review of the Pre-Audit Questionnaire (PAQ), documentation review on the agency, email correspondence, and telephone calls.

A certified PREA audit was conducted at the Ft. Bellefontaine program located in St. Louis, MO on 4/6 - 4/8, 2021. The Ft. Bellefontaine facility hereinafter may be referred to as a program or facility. It should be noted that, for the purpose of this audit report, the resident housed at the program will be called "resident"

The auditor used a triangular approach, by connecting the PREA audit documentations, on-site observation, facility walk through, practice, interviewed staff, residents, and local and national advocates to make determinations for each standard.

Pre-onsite Audit Phase

Posting: On 2/1/2021, the auditor provided the audit notice to the Ft. Bellefontaine facility PREA coordinator (PC), with instruction to post the required PREA Audit Notice of the upcoming audit prior to the audit for confidential communications. Photos were sent to the auditor on 2/19/2021, indicating that the facility posted the notices in English and Spanish. The auditor received photos of the timestamp posted notices, located in common areas. The auditor did not receive communication from any residents.

Pre-Audit Questionnaire (PAQ): In order to prepare for the audit process, pre-kick off email correspondence occurred with the agency's PREA coordinator (Judy Parrett/Jennifer Hanes) on 1/27/2021. As the auditor reviewed the materials provided by the facility, any outstanding documents were communicated directly with the agency PREA coordinator. Completed documents were submitted or discussed via telephonic and email correspondence.

The Pre-Audit Questionnaire was completed and sent to the auditor as required. The completed Pre-Audit Questionnaire (PAQ) was submitted on 3/15/2021. Additional documentation received included agency policies, procedures, forms, education materials, training curriculum, organizational charts, posters, brochures and other PREA related materials were also provided. The lead auditor reviewed all the documentation submitted by the facility and prepared a list of issues based on the evidence provided. Any pre-audit issues were directly discussed with the PREA coordinator.

The auditor completed a documentation review using the Pre-Audit Questionnaire (PAQ), internet search, policies and procedures review, and additional documentation provided via email correspondence; to include both the agency and the program policy and procedures, agency mission statement, daily population report, and schematic/layout for the program. The auditor was provided a list of requested documents for the on-site review. As the auditor reviewed the materials provided by the program, the content/documents were organized and any outstanding issues/concerns were addressed via telephonic and email correspondence, with the agency PREA coordinator. It should be noted that a list of random and special categorized residents was provided during the on-site review.

Website Review: Prior to the on-site portion of the audit, the auditor conducted a website review. There were no articles/publications identified in the website review.

Prior to the on-site portion of the audit, the auditor was made aware that the facility did not house female residents or residents who were held for immigration purposes. Email communication was sent to the PREA coordinator requesting the following information in preparation for the site review:

- Staffing Plan/Documentation of deviation for the staffing plan
- Annual Reviews
- Logs of exigent circumstances for cross gender pat down searches (if applicable)
- Staff training logs
- Written materials used for effective communication about PREA residents with disabilities or limited reading skills
- Documentation of staff training on PREA complaint practices for residents with disabilities
- Documentation of investigators who have completed specialized investigative training (if app
- Documentation of mental health and medical staff that have completed specialized training
- Screening instrument used to determine risk for victimization
- Documentation of use of screening information to inform housing, bed, work, education and program assignments with the goal of keeping separate those residents with a high risk of being sexually abusive
- Sample resident grievances (on-site will review general grievances filed)
- Resident handbook
- Documentation of notifications of abuse while confined at another facility (if applicable)
- Facility institutional plan (coordinated plan)
- Retaliation reports (all investigation files, last 12 months)
- Documentation when segregated housing was used to house residents who have alleged to have suffered sexual abuse (if applicable)
- Sample of investigations of alleged sexual abuse complaints completed by the agency
- Sample of investigations of alleged sexual abuse complaints completed by outside agency
- Sample of documentation of any substantiated or unsubstantiated complaints
- Sample of documentation of notifications
- Sample records of terminations, resignations, or other sanctions against staff—allegations of sexual abuse or sexual harassment—within the last 12 months – (may request to review more sexual harassment while on site)
- Reports of sexual abuse of residents by contractors or volunteers
- Sample records of disciplinary actions against residents for sexual conduct with staff
- Sample records of disciplinary actions against residents for sexual conduct against other residents (need substantiated abuse or harassment allegations)
- Documentation of sexual abuse incident reviews
- Sexual abuse reports
- Unannounced rounds documentation

- A summary of all incidents within the past 12 months (log)
- All transgender evaluations completed in the last 12 months
- Rosters
- Notice of auditor post-English/Spanish (received)
- Residents with disabilities
- Residents who are limited English proficient (LEP)
- LGBTI residents
- Residents in segregated housing (PREA related)
- Residents who reported sexual abuse
- Residents who reported sexual victimization during risk screening
- Staff roster
- Specialized staff list
- Staff personnel documentation
- Resident documentations
- List of contractors who have contact with residents
- List of volunteers who have contact with residents
- PREA reassessments (all sexual abuse cases)

On-Site Audit Phase

Team Composition/Entrance

The audit team consisted of the auditor (Latera Davis) and associate (Debaja Coleman). On 4/6/2021 at approximately 8:00 am the auditor arrived at the facility to conduct an entrance meeting with the facility Manager/PREA compliance manager and the PREA coordinator; along with beginning the on-site process (physical plant inspection and interviews).

Entrance Meeting

The entrance meeting served as initial introductions and on-site logistics with the program leadership. The auditor reiterated the PREA Resource Center's (PRC) expectations of the on-site process and written reports, along with the audit goals. The auditor provided an overview of the expectations during the on-site audit and transparency to discuss any identified issues or concerns. The team also established a process to make corrections on-site, if necessary and post on-site follow up.

Prior to the on-site audit and upon conclusion of the entrance meeting, the auditor was provided agency and employee documentation to review. It should be noted that resident information was only provided onsite as the agency does not allow the release of resident information. If audited the agency will provide the requested documents.

During the onsite portion of the audit, resident and staffing lists were also provided allowing the audit team to make randomized selections of interview participants. The Ft. Bellefontaine program direct care staff work 8-hour shifts; with three respective shifts.

Day One: The auditor conducted the physical plant site inspection along with staff and resident interviews.

Day Two-Three: The auditor completed the remaining interviews (resident and staff) and file review. Upon completion of assigned tasks, auditor returned to the assigned office to discuss site observation, informal and formal interviews, file review, and necessary corrective actions. Day three also served as the close out conference.

Interviews: Due to COVID-19, and the need to take extra safety precautionary measures; resident and informal auditor contact during the walk through was limited. The auditor was able to have informal discussion with five resident while conducting the physical plant inspection. During the informal discussion, the resident were aware of PREA. The resident could tell the auditor about the hotline and the purpose of PREA.

For the formal interviews, the auditor selected names of all individuals who were scheduled for work, and the facility staff prepared the residents and staff members for interview in a staged manner. For all completed interviews, appropriate PREA-interview protocols were utilized, and standard advisory statements were communicated with the interviewing audit team member recording responses by hand or typed.

On the first day of the on-site audit there were 10 residents reported at the program. Staff interviews were based on who was at the program on the days of the audit, varying staff shifts, and positions/roles held. Over the three days being on-site, 23 interviews were conducted with staff that have specialized roles and responsibilities. It should be noted that this also included staff that have dual role responsibilities. The interviews were conducted privately in several different meeting rooms and the protocols used included but were not limited to incident review team members, mental health staff, screening staff, security first responder, agency head, staff who supervise residents in isolation, agency contract administrator, HR administrator, intake staff, PREA coordinator, intermediate or higher-level staff, facility director, medical staff, and staff who monitor for retaliation. The Ft. Bellefontaine program did not have any approved volunteers at the program.

Along with the specialized staff, 10 random staff were interviewed. Random staff were chosen by retrieving a list of staff from every shift, including new and more tenured staff. A total of zero targeted resident interviews were identified. There were no residents housed for the sole purpose of immigration. It was also reported that there were no residents segregated for risk of sexual victimization, which was confirmed through staff and resident interviews, as well as site review by audit team members. The interviews were conducted primarily in an empty offices or staff offices and telephonic communication.

The sampling strategy included interviewing all residents which included a selection of targeted residents within the sample of participants. Interviews were conducted using the Department of Justice (DOJ) protocols to assess the resident's knowledge of PREA and reporting mechanisms available to them at the Ft. Bellefontaine program.

***It should be noted that some of the same resident were selected for random and targeted interviews, due to the capacity of the program.

Category of Residents	Total Number	Number of Interviews
Random residents	10	10
Targeted residents	0	0
Total Residents Interviewed	10	10
Breakdown of Targeted Residents Interviewed		
Residents with disabilities	0	0
Residents who are blind, deaf, or hard of hearing	0	0
Residents who are LEP	0	0
Residents with cognitive disabilities	0	0
Residents who are LGB	0	0
Residents who Identify as transgender or intersex	0	0

Residents who reported sexual abuse that occurred at the facility ***no current residents	0	0
Residents who reported sexual victimization during risk screening	0	0
Resident segregated housing for sexual victimization	0	0
Category of Staff Interviewed *** It Should Be Noted That Some Interviews Conducted Duplication of The Same Staff.		
Random staff	12	12
Specialized staff	33	23
Agency head	1	1
Program director (manager)	1	1
PREA compliance manager	1	1
PREA coordinator	1	1
Total Staff Interviewed	49 (Total staff roles)	39 (Total Interviewed)
Breakdown of Specialized Staff		
Contract administrator	1	1
Intermediate or higher-level staff responsible for conducting and documenting unannounced rounds	2	2
Medical staff	1	1
Mental health staff	1	1
Non-medical staff involved in cross gender searches (f applicable)	0	0
Volunteers Who Have Contact with Residents	0	0
Contractors Who Have Contact Residents	7	1
Investigators		
Staff Who Perform Risk for Victimization and Abusiveness	1	1
Staff Who Screen Resident in Segregated Housing	0	0
Designated Staff Members Charged with Monitoring for Retaliation	1	1
First Responders ***all direct care considered 1st responders	12	12
Education	1	1
Incident Review Team	5	1
HR Administrator	1	1

Site Review: The auditor conducted a comprehensive site review of the program. Residents had access on-site and could be present. The program teacher assisted in escorting the auditor throughout the program during the inspection. The facility has one stand-alone buildings (main) and two separate shared buildings (education building and cafeteria).

During the site review, the following areas were inspected:

- Main (3 levels)
    - Lower level
        - Shower/bathrooms
        - Equipment/storage
        - Recreation Room
        - Laundry Room
    - Main level
        - Recreation Room
        - Open hallway (staff snack machine and lockers)
        - Cleaning closet
        - Dayroom
        - Kitchen
    - Upper level
        - Open bay-Dorm (12 bunks)
        - Admin Offices (3)
        - Medical Closet
        - Classroom
    - Education Building (separate shared building)
    - Cafeteria (separate shared building)

It should be noted that the auditor observed two buildings during the on-site inspection.

The Ft. Bellefontaine program is a staff secured facility for males in the State of Missouri. The facility consists of one building with one housing unit.

The auditor inspected facility doors, restrooms, housing, and office areas. The areas were consistently secured and locked. Inspections of bathroom and shower areas were conducted, with observation of possible cross-gender viewing. The bathrooms in the housing room have limited privacy. It was reported that the residents only using the bathrooms in the housing area as needed. The bathrooms on the lower level are what are primarily utilized.

The living unit contains 12 bunk beds, a toilet, and sink. The lower level contains a lavatory, resident showers and toilets. Residents shower by themselves. It was observed that the facility did not have adequate shower curtains. The curtains were replaced immediately and prior to the close out of the onsite audit.

The classrooms have visual site observation windows, where staff can see in and out of the classroom. The education area is always staffed with direct care workers. The residents have phone access on the housing unit; however, they must seek permission to use. There is a phone that the resident can use in the hallway near the classroom that has a longer cord to allow for privacy. During the tour, the residents reported knowing the number for the PREA hotline and feeling comfortable to make calls. During the onsite inspection, the auditor noticed that there were PREA posters located on the housing unit, day rooms, recreation rooms, hallways, and in education.

Due to no new intakes, the audit team was not able to observe a portion of the resident intake/orientation process. The auditor was provided unimpeded access to all parts of the facility and all secure rooms and storage areas in the facility. There were no locations of concern identified during the tour.

The PREA audit requires the auditor to conduct outreach to relevant national and local advocacy organizations. To communicate with community-based or victim advocates who may have insight into

relevant conditions in the facility. The following national advocacy, State, and/or community advocacy organizations were contacted.

Advocacy Organization	Date Received
Just Detention International (JDI)	2/5/2021
RAINN	4/20/2021

The auditor asks the advocacy organizations the following questions:

How many residents reported sexual abuse and/or sexual harassment in the last 12 months?

Have you received any reports on the program in the last 12 months?

Documentation Review and Sampling

Documents Reviews: During the site review, documentation review included, but was not limited to the auditor review of personnel files, training records, resident intake, screening, and PREA education records; and any other related documents that covered the prior 12-month period. The documentation review process was covered by the auditor. The PAQ reported zero investigations.

Records Review

Name of record	Total # of records	# sampled and reviewed
Staff personnel records	28	28
Volunteers and contractor personnel record	7	7
Training files/documentation/records (staff, contractor, volunteer)	28	28
Medical/mental health records (victims) Resident contact after report SH/SA and intake screening	0	0
Intake files (resident education/SVAT) ***Records of youth placed after the start of audit reviewed as well.	25	23
Investigation Records	3	3

Investigations Review

	Sexual Abuse		Sexual Harassment	
	Resident on Resident	Staff on Resident	Resident on Resident	Staff on Resident
Hotline	0	2	0	0
Grievance	0	0	0	0
Reports to Staff	0	1	0	0
Anonymous, 3rd party	0	0	0	0
Reports by Staff	0	0	0	0

Grievances: The Ft. Bellefontaine program has grievance forms located throughout the building. The agency does not use the grievance process to address PREA related allegations; however, the resident

can make a report using the grievance system. There were no reported grievances filed in the last 12 months. The program manager reported that resident do not typically use the grievance system, as they have meetings every week to address any identified questions or concerns.

Informational Consolidation: The auditor met frequently with agency leadership, throughout the two days to consolidate information and ensure that the interviews, documentation reviews, and program observations supported a compliance determination for the required PREA standards. The team met on-site and off-site to discuss findings. When additional information was requested to establish compliance, the management team was responsive and made every effort to deliver documentation. The program staff was receptive to providing additional documentation along with noted concerns in documentation review.

Exit Briefing

The audit team conducted an exit meeting on 4/8/2021, at which preliminary findings of the review were discussed with the program leadership team. During the exit, the auditor provided an overview of the on-site inspection results and discussion of follow up requested information.

Post-Onsite Audit Phase

Upon return from the on-site phase of the audit, the auditor, and the agency PREA coordinator agreed to communicate by email and telephone during the post-audit phase, regarding any identified need for additional documentation, as well as clarification of questions that arose while collating data.

Communication with the agency PREA coordinator began immediately upon the conclusion of the on-site audit. Communication was ongoing, with responses provided consistently both by email and telephone. Documentation and clarification communication emails facilitated the ability to process both the Interim and Final Reports.

Audit Section of the Compliance Tool: The auditor continued to review documentation and interview notes gathered while on-site and compile information to enter the audit portion of the compliance tool. Detailed information from the audit interviews were integrated into relevant sections of the standards. To ensure all standards were thoroughly analyzed, the auditor proceeded standard by standard, determining compliance or non-compliance.

Interim Audit Report: The auditor completed entry of data into and determination of standard compliance on the Audit Compliance Tool and began writing of the Interim Report. The Interim Report included reference to policies and procedures, agency and facility reports, and supplementary documentation provided by the facility and during the site review, supporting information gathered during site review, as well as aggregated and de-identified information regarding interviews conducted for the purposes of this audit. The auditor incorporated evidence gathered on-site and through documentation review as proof for the conclusion of whether the facility exceeded, met, or did not meet the standard of review.

Final Audit Report: 5/22/2021

Facility Characteristics

The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate, resident or detainee population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of facilities and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

Facility Demographics

Total positions assigned to location: 13

- Facility Manager – 1
- Office Support Assistant - 1
- Youth Specialist- 9 ***1 vacant
- Group Leaders - 1
- Coordinated Medical Services – 1***position does not belong to the program
- Coordinated Mental Health Services-1***position does not belong to the program

Volunteer – 0 ***services not functioning at this time due to COVID-19

Contractors – 7 Contracted maintenance services

Program Description

Ft. Bellefontaine Hall Program Description: Ft. Bellefontaine Hall is a 12-bed moderate level care facility located in the Ft. Bellefontaine County Park on the Missouri Hills Campus in St. Louis, MO. The facility has one group of male youth generally ranging in age from 12- 17 years. They have been committed to the care and custody of the Division of Youth Services through the juvenile court system. Ft. Bellefontaine Hall serves youth from the four counties that make up the St. Louis Region. Generally, youth are committed to this facility for offenses ranging from Assault to Tampering and many youth in care have experienced prior out of home placements.

Ft. Bellefontaine Hall employs nine full time Youth Specialists, one Group Leader, one Academic Teacher, one Office Support Assistant and one Facility Manager. Medical services are coordinated by the Regional nurse, Facility Manager and/or the Assistant Regional Administrator. 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 the facility.

Youth also have opportunities for outdoor recreation, community service, education outings and can be employed by the Jobs Program on the campus. 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's strengths and assets, are trauma informed and incorporate positive youth development principles. All of this is completed within the framework of the youth's well-being including mastery, stability, safety, access to mainstream relevant resources and social connections. Education is an important part of the youth's program to assist them in future success. Youth are able to continue to work toward obtaining their high school diploma or may study toward achieving a High School Equivalency certificate and some move forward and prepare for college by taking their ACT.

Facility services are also supplemented by DYS Family Specialists, Treatment Coordinators, Regional Clinical Coordinator and Community Mentors. All youth are assigned an individual Service Coordinator to assist them in their progress from their commitment to DYS up until their eventual discharge. Youth can have access to psychiatric services through contracted providers. Ft. Bellefontaine Hall and DYS believe that family is vital to the treatment process. Youth and families are encouraged to build and strengthen relationships through phone calls, visitation and active participation in the youth's progress.

Campus Description

Missouri Hills Campus sits on approximately fifty acres of land with trees, trails and a large amount of open grassland. On Missouri Hills Campus there is a security check in at a gate and then six residential cottages, only four are occupied at present, which house youth one cottage houses female youth and the other three male youth. There is also one administration building, one building that includes the gymnasium, cafeteria and maintenance then there is a separate school building. There is a building that has food storage and maintenance storage, a vocational building, a building that holds the generator, a soccer field, a softball field and a sand volleyball court. Also on the campus there is a high and low ropes course that is behind the school inside the woods and a climbing tower that is attached to that course

Summary of Audit Findings

The summary should include the number and list of standards exceeded, number of standards met, and number and list of standards not met.

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

Standards Exceeded

Number of Standards Exceeded: 2

List of Standards Exceeded: Click or tap here to enter text.

Prevention and Planning

-115.313 Supervision and Monitoring

-115.331 Employee Training

Standards Met

Number of Standards Met: 41

Prevention and Planning

- 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
- 115.312 Contracting with other entities for the confinement of residents
- 115.315 Limits to cross-gender viewing and searches
- 115.316 Residents with disabilities and inmates who are limited English proficient
- 115.317 Hiring and promotion decisions
- 115.318 Upgrades to facilities and technologies

Responsive Planning

- 115.321 Evidence protocol and forensic medical examination
- 115.322 Policies to ensure referrals of allegations for investigation

Training and Education

- 115.332 Volunteer and contractor training
- 115.333 Resident education
- 115.334 Specialized training: Investigations
- 115.335 Specialized training: Medical and mental health care

Screening and Risk of Sexual Victimization and Abusiveness

- 115.341 Obtaining information from residents
- 115.342 Placement of residents in housing, bed, program, education, and work assignment

Reporting

- 115.351 Resident reporting
- 115.352 Exhaustion of administrative remedies
- 115.353 Resident access to outside confidential support service
- 115.354 Third-party reporting

Official Response Following a Resident Report

- 115.361 Staff and agency reporting duties
- 115.362 Agency protection duties
- 115.363 Reporting to other confinement facilities
- 115.364 Staff first responder duties
- 115.365 Coordinated response
- 115.366 Preservation of ability to protect residents from contact with abusers
- 115.367 Agency protection against retaliation
- 115.368 Post-allegation protective custody

Investigation

- 115.371 Criminal and administrative agency investigations
- 115.372 Evidentiary standard for administrative investigations
- 115.373 Reporting to residents

Discipline

- 115.376 Disciplinary sanctions for staff
- 115.377 Corrective action for contractors and volunteers
- 115.378 Disciplinary sanctions for residents

Medical and Mental Care

- 115.381 Medical and mental health screenings
- 115.382 Access to emergency medical and mental health services
- 115.383 Ongoing medical and mental health care for sexual abuse victims and abusers

Data Collection and Review

- 115.386 Sexual abuse incident reviews
- 115.387 Data collection
- 115.388 Data review for corrective action
- 115.389 Data storage, publication, and destruction

Audits and Corrective Action

- 115.401 Frequency and scope of audits
- 115.403 Audit content and findings

Standards Not Met

Number of Standards Not Met: 0
List of Standards Not Met: Click or tap here to enter text.

Summary of Corrective Action:

115.315- During the onsite inspection, it was observed that the facility did not have adequate PREA shower curtains. The facility made corrections, by replacing the shower curtains prior to the completion of the onsite portion of the audit. There is no further action needed. Standard is found compliant.

115.333- While the youth reported receiving PREA education, ten of their signed forms were not located. During the onsite audit, the youth were given refresher training on PREA and signed documentation acknowledging receipt. There is no further corrective action needed.

115.335- While medical and mental health staff previously received specialized training; the interviewed medical staff responses were not always consistent with the standard and agency policies. The auditor

recommended refresher training. Refresher training occurred on 5/1/2021; prior to the initial report. No further action needed.

115.341- Upon review of the PVIRs it was identified that the PVIRs were not being completed according to instruction. The auditor recommended that the facility manager complete a refresher training on how to complete the PVIRs. The refresher training was conducted on 5/3/2021. Additionally, the facility shall provide completed PVIRs, showing proof of corrected completion. Two PVIRs were provided, demonstrating the ability to complete the forms in the correct manner. No further action required.

115.342- Upon review of the PVIRs it was identified that the PVIRs were not being completed according to instruction. The auditor recommended that the facility manager complete a refresher training on how to complete the PVIRs. The refresher training was conducted on 5/3/2021. Two PVIRs were provided, demonstrating the ability to complete the forms in the correct manner. No further action required.

115.378- While medical and mental health staff previously received specialized training; the interviewed medical staff responses were not always consistent with the standard and agency policies. The auditor recommended refresher training. Refresher training occurred on 5/1/2021; prior to the initial report. No further action needed.

115.381- Upon review of the PVIRs it was identified that the PVIRs were not being completed according to instruction. The auditor recommended that the facility manager complete a refresher training on how to complete the PVIRs. The refresher training was conducted on 5/3/2021. Two PVIRs were provided, demonstrating the ability to complete the forms in the correct manner. No further action required.

115.383- While medical and mental health staff previously received specialized training; the interviewed medical staff responses were not always consistent with the standard and agency policies. The auditor recommended refresher training. Refresher training occurred on 5/1/2021; prior to the initial report. No further action needed.

PREVENTION PLANNING

Standard 115.311: Zero tolerance of sexual abuse and sexual harassment; PREA coordinator

All Yes/No Questions Must Be Answered by The Auditor to Complete the Report

115.311 (a)

- Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the written policy outline the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment? ☒ Yes ☐ No

115.311 (b)

- Has the agency employed or designated an agency-wide PREA Coordinator? ☒ Yes ☐ No
- Is the PREA Coordinator position in the upper-level of the agency hierarchy? ☒ Yes ☐ No
- Does the PREA Coordinator have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities? ☒ Yes ☐ No

115.311 (c)

- If this agency operates more than one facility, has each facility designated a PREA compliance manager? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA
- Does the PREA compliance manager have sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards? (N/A if agency operates only one facility.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents: (Policies, directives, forms, files, records, etc.):
   a. Pre-Audit Questionnaire (PAQ)
   a. Policy 9.18, *Prison Rape Elimination Act (PREA)*
   b. Policy 3.8, *Employee Conduct*
   c. Policy 3.23, *Ethical Standards*
   d. Organizational Chart
2. Interviews:
   a. PREA Coordinator
   b. PREA compliance manager

Findings (By Provision):

115.311 (a). The Ft. Bellefontaine facility is governed by the Missouri Division of Youth Services/Department of Social Services. As reported in the PAQ, the agency has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract. The facility reported having a policy outlining how it will implement the agency's approach to prevent, detect, and respond to sexual abuse and sexual harassment. The agency's policies include definitions of prohibited behaviors regarding sexual abuse and sexual harassment.

The DYS Policy 9.18, *(p.1)*, states that:

> Division of Youth Services (DYS) is committed to a zero-tolerance standard for incidents of sexual abuse and sexual harassment. The purpose of this policy is to describe how the Prison Rape Elimination Act (PREA) per 28CFR Section 115.5-115.501 shall be implemented within DYS. This policy provides the division's approach to preventing, detecting, and responding to such conduct, within DYS residential and county detention centers contracted for reception and detention services.

Policy 3.8 further states that:

> Employees are expected to be respectful and kind in their communication with resident, co-workers and others. Employees shall not engage in language or conversation that is demeaning or otherwise perceived as offensive to resident or employees. This includes, but is not limited, to name calling, cursing, telling jokes that are demeaning to others, shaming, blaming or threatening resident, co-workers or employees. See DSS Administrative Policies 2-115 (Work Rules) and 2-120 (Code of Conduct) *(p. 4)*.

The agency policy also guides the interactions between staff and residents. Policy 3.23, states that:

> DYS employees shall not engage in any activity that exploits resident or families including, but not limited to, social or business relationships, sexual abuse or sexual harassment to including, but not limited to, kissing, touching or caressing, exhibitionism, voyeurism, comments, gestures, physical contact, sexual advances, flirtation, requests for sexual favors, and any other verbal or physical conduct of a sexual nature *(p.1)*.

The agency policy includes a description of the agencies strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents. Policy 9.18, states that, "DYS employees shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies as defined in this policy, DSS Policy 2-124 Discipline, DSS Policy 2-101 Sexual Harassment/ Inappropriate Conduct and DYS Policy 3.8 Employee Conduct" *(p. 14*).

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.311 (b). The Ft. Bellefontaine facility employs an upper level, agency wide PREA coordinator, Jennifer Hanes/Judy Parrett. According to the agency organizational chart, the agency PREA coordinator reports to the Division Director. The Ft. Bellefontaine facility organizational chart provides information on the PREA compliance manager.

The interviewed PREA coordinator reported that she has adequate time to manage all PREA related duties. The PREA coordinator has responsibility for 21 PREA compliance managers. In that responsibility she will conduct PREA Compliance manager Training and refresher training, phone, email, face-face meetings/walk through of facility. Additionally, provide each with a resource manual for PREA, review during trainings. Track PREA incidents, required documentation and timelines.

It should be noted that the agency is in the process of training a new person to serve as the agency PREA coordinator. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.311 (c). According to the PAQ, the Ft. Bellefontaine Campus facility has a designated PREA compliance manager. The PREA compliance manager reported having sufficient time to complete job duties. The Ft. Bellefontaine Campus facility provided an organizational chart outlining the setup of the organization.

Corrective Action:
No corrective action is recommended for this standard

Standard 115.312: Contracting with other entities for the confinement of residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.312 (a)

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to adopt and comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☒ Yes ☐ No ☐ NA

115.312 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

3. Documents: (Policies, directives, forms, files, records, etc.):
   b. Pre-Audit Questionnaire (PAQ)
4. Interviews:
   a. Agency Contract Administrator

Findings (By Provision):

115.312 (a). The Pre-Audit Questionnaire (PAQ) indicated that the agency has entered into or renewed 12 contracts for the confinement of residents on or after August 20, 2012 or since the last PREA audit.

115.312 (b). As reported in the PAQ, all of the above-mentioned contracts require the agency to monitor the contractor's compliance with PREA standards. The interviewed agency contract administrator reported that she works with the DYS account manager and Division of Finance and Administrative Services contract unit during assessment of bids prior to contracts being awarded. The contract administrator also reported that the PREA compliance results have been completed for each contract entered into agreement within the past 12 months. The agency contract administrator reported that current sites DYS contracts with were audited and found to be compliant 2018/2019 and are scheduled for audits starting in September 2021.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.313: Supervision and monitoring

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.313 (a)

- Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?

- ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Generally accepted juvenile detention and correctional/secure residential practices? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any judicial findings of inadequacy? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from Federal investigative agencies? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from internal or external oversight bodies? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The number and placement of supervisory staff? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Institution facilitys occurring on a particular shift? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any applicable State or local laws, regulations, or standards? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any other relevant factors? ☒ Yes ☐ No

115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? ☒ Yes ☐ No

- In circumstances where the staffing plan is not complied with, does the facility document all deviations from the plan? (N/A if no deviations from staffing plan.) ☐ Yes ☐ No ☒ NA

115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".)
  ☒ Yes ☐ No ☐ NA

- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".) ☒ Yes ☐ No ☐ NA

- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".) ☒ Yes ☐ No ☐ NA

- Does the facility ensure only security staff are included when calculating these ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".) ☒ Yes ☐ No ☐ NA

- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? ☒ Yes ☐ No

115.313 (d)

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The staffing plan established pursuant to paragraph (a) of this section? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The resources the facility has available to commit to ensure adherence to the staffing plan? ☒ Yes ☐ No

115.313 (e)

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents: (Policies, directives, forms, files, records, etc.):
   c. Pre-Audit Questionnaire (PAQ)
   a. Policy 9.6, *Facility Supervision*
   b. Policy 9.18, *Prison Rape Elimination Act (PREA)*
   c. Staffing Plan -General
   d. Unannounced Rounds (*Unannounced Program Visits*) - 40
   e. Shift rosters – 1 month
   f. Annual Staffing Plan-2018-2020
2. Interviews:
   a. Manager
   b. PREA coordinator
   c. PREA compliance manager
   d. Intermediate or higher-level staff
   b. -

Findings (By Provision):

115.313 (a). The facility indicated in their responses to the Pre-Audit Questionnaire that the agency ensures that each facility it operates develops, implements, and documents a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against

sexual abuse. In calculating these adequate staffing levels and determining the need for video monitoring, facilities shall take into consideration all relevant factors. It further indicated that the average daily number of residents since the last PREA audit is 16. Additionally, the average daily number of residents in which the staffing plan was predicted is 24. The Ft. Bellefontaine Campus facility provided policies, annual staffing plans, unannounced rounds reports, and shift rosters as documentation; showing that a staffing plan is being utilized as developed.

Policy, 9.6, states that:

1. Employee Shift Scheduling:
    a. **Secure Care:** Minimally, two direct care employees are scheduled and required to be with each group of resident on all shifts at all times. In addition, **at least** one (1) rover, per facility shall be scheduled per shift. The RA in conjunction with the ARA and site supervisor are responsible for increased coverage on specific shifts based on the needs of the facility.
    b. **Moderate Secure:** Two direct care employees are scheduled and required to be with each group of resident during the day and evening shifts. A minimum of one (1) direct care employees per group and one (1) rover per facility shall be scheduled during the overnight shift. Exceptions to rover requirements may be made for multi-facility campuses (Missouri Hills, Sears) with prior approval by the RA and the supervising deputy director. The RA in conjunction with the ARA and site supervisor may increase coverage on specific shifts based on the needs of the facility.
    c. **Community Based:** At minimum, one (1) direct care employee is required to be scheduled with each group for all shifts; however, every effort shall be made to ensure two (2) direct care employees are scheduled with each group of resident during the day and evening shifts. The RA in conjunction with the ARA and site supervisor may increase coverage on specific shifts based on the needs of the facility.
    d. In exigent circumstances and with supervising deputy director or designee approval, deviation below the minimums noted above may occur. Such deviation shall be documented, copied to the RA and supervising deputy director, and maintained by the Facility Manager *(pp. 3-4)*.

The interviewed PREA compliance manager/facility manager reported that the agency has a policy to assess staffing plans and such plans are reviewed annually. The facility follows the 1:8 and 1:16 staffing requirements and they typically have a 2:12 day and 3:12 evening ratio. The facility manager will monitor for compliance by addressing issues, retrain staff, and check for blind spots, staff logs, and schedules.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted. No matter what the population is there are always at least two staff with each assigned group.

115.313 (b). According to the PAQ the Ft. Bellefontaine Campus facility has not deviated from the staffing plan. The Ft. Bellefontaine Campus facility operates a staffing plan that meets the PREA ratio standards.

Policy 9.6 further states that, “Each residential facility shall maintain a staffing plan based on the size and security level of the facility that meets the staffing ratios as requirements by this policy. The staffing plans shall be reviewed as deemed necessary but at least in March of each year by the facility manager with input from the ARA and RA. The assessment shall determine and document whether adjustments are

needed in accordance with PREA Standard 115.313. A copy of the staffing plan and annual review shall be maintained by the Statewide PREA Coordinator" (*pgs. 3-4*).

The Ft. Bellefontaine facility provided documentation of the staffing shift/roster. The staffing plan covers three shifts for the weekday and weekends: along with the supervisor on duty. The interviewed facility manager reported that they have not had any circumstances where the facility has been unable to meet the requirements of the staffing plan. If there is any concern staff will be held over for proper relief. The current resident to staff requirements, exceeds PREA standards.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.313 (c). According to the PAQ, the Ft. Bellefontaine Campus facility met staffing ratios by maintaining the staffing ratios of minimum 1:8 during resident waking hours and 1:16 during resident sleeping hours. As reported, the facility has not deviated from the staff ratios of 1:8 during waking hours and 1:16 during resident sleeping hours.

Policy, 9.18 states that, "DYS shall ensure that its residential staffing and monitoring plans comply with DYS Policy 9.6 Facility Supervision which meets those 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" *(p. 4*).

The interviewed manager stated that Missouri doesn't laws and regulations governing the site exceed the PREA standards; however, there is agency policy. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.313 (d). According to the Ft. Bellefontaine Campus Facility Staffing Plan there have been no known changes to the staffing numbers within the last 12 months. As reported in the PAQ, at least once a year the facility, in collaboration with the agency's PREA coordinator; reviews the staffing plan to see whether adjustments are needed to:

- The staffing plan;
- Prevailing staffing patterns
- The deployment of monitoring technology; or
- The allocation of agency or facility resources to commit to the staffing plan to ensure compliance with the staffing plan.

Policy 9.6 states that, "Each residential facility shall maintain a staffing plan based on the size and security level of the facility that meets the staffing ratios as requirements by this policy. The staffing plans shall be reviewed as deemed necessary but at least in March of each year by the facility manager with input from the ARA and RA. The assessment shall determine and document whether adjustments are needed in accordance with PREA Standard 115.313. A copy of the staffing plan and annual review shall be maintained by the Statewide PREA Coordinator" *(p. 4*).

The interviewed PREA coordinator reported that the facility consults with the PREA coordinator when discussing staffing plans. "A statewide discussion would occur during policy and regulation meetings of which the Statewide PREA coordinator attends. Individual PREA Compliance managers provide the Statewide PREA coordinator annual assessments of their staffing plans and copies of the *Critical Incident Reviews* that includes an assessment of the staffing plan."

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.313 (e). As reported in the PAQ, the Ft. Bellefontaine Campus facility has a policy and practice in place where intermediate or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment. It was further reported that the unnanounced rounds covered all shifts. The auditor reviewed 40 unannounced rounds (*Unannounced Walk Throughs*); confirming the facility practice of conducting documented unannounced rounds.

Policy 9.6, states that:

- Unannounced facility visits shall be conducted at all facilities for all shifts, at least quarterly. These visits shall be conducted by the Facility Manager, Assistant Facility Manager, ARA or RA.
- Employees are prohibited from alerting each other that these unannounced visits are occurring, unless such announcement is related to the legitimate operational functions of the facility. Violation of this directive shall be grounds for disciplinary action up to and including dismissal in accordance with DSS 2-124 Discipline" (pg. 5).

Two intermediate or higher-level staff members were interviewed, and reported unannounced rounds are conducted and documented. The unannounced rounds are conducted at random times during various shifts; but at least three times per month. Staff have also been informed that they are not permitted to alert other staff of random visits. One way they would monitor is to listen to radio frequency. It was also reported that some of the things they will look for are: staffing, interaction of staff and resident, activities being conducted, where resident are housed, etc. There is a form that is completed to document the unannounced rounds.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.315: Limits to cross-gender viewing and searches

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.315 (a)

- Does the facility always refrain from conducting any cross-gender strip or cross-gender visual body cavity searches, except in exigent circumstances or by medical practitioners?
  ☒ Yes ☐ No

115.315 (b)

- Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances? ☒ Yes ☐ No ☐ NA

115.315 (c)

- Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches? ☒ Yes ☐ No

- Does the facility document all cross-gender pat-down searches? ☒ Yes ☐ No

115.315 (d)

- Does the facility have policies that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No

- Does the facility have procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No

- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? ☒ Yes ☐ No

- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units) ☐ Yes ☐ No ☒ NA

115.315 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? ☒ Yes ☐ No

- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? ☒ Yes ☐ No

115.315 (f)

- Does the facility/agency train security staff in how to conduct cross-gender pat down searches in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

- Does the facility/agency train security staff in how to conduct searches of transgender and intersex residents in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy 5.8, *Searches for Contraband*
    c. Policy 9.18, *Prison Rape Elimination Act (PREA)*
    d. Policy 9.6, *Facility Supervision*
    e. Policy 7.2, *Standards*
    f. Staff Training Records/New Hire– 28
    g. Division of Youth Services Training Guide for physical searches of a resident in a residential setting
2. Interviews:
    a. Random sample of staff -12
    b. Random sample of residents - 10

Findings (By Provision):

115.315 (a). As reported in the PAQ, the Ft. Bellefontaine facility does not conduct cross-gender strip or cross gender visual body cavity searches of residents. In the past 12 months there have been zero reported cross-gender strip or cross gender visual body cavity searches of residents. Policy 5.8, Searches, states that, "DYS will not perform body cavity or strip searches under any circumstances" *(p. 4)*. The policy further states that "personal searches will be conducted by a division employee in the presence of another division employee. Except in exigent circumstances the individual conducting the search shall be of the same gender of the resident. If a cross-gender search occurs it shall be documented. For such searches that were conducted in a residential facility, this documentation shall be maintained by the PREA Compliance manager" *(p. 5)*.

115.315 (b). The facility reported in the PAQ that it does not permit cross-gender pat-down searches of residents, absent exigent circumstances. It was also reported that there were zero pat-down searches of female residents that were conducted by male staff; and zero pat down searches of male residents conducted by female staff that did not involve exigent circumstances. As previously stated, Policy,

Searches, further reiterates that, will be conducted by a division employee in the presence of another division employee. Except in exigent circumstances the individual conducting the search shall be of the same gender of the resident. If a cross-gender search occurs it shall be documented. For such searches that were conducted in a residential facility, this documentation shall be maintained by the PREA compliance manager.

Twelve staff, representing staff from all three shifts, were interviewed. The staff expressed that they would only conduct cross-gender pat down searches in exigent circumstances and if the safety of others were at risk. All twelve staff stated they would attempt all other options first before conducting a cross gender pat down search to include calling another staff from another building. Facility has a process that require residents to conduct a search on themselves in a circle. The staff gives directions to youth regarding conducting the personal search.

Ten residents stated they have never been searched by the opposite sex while being detained at Ft. Bellefontaine Facility. Residents all stated that staff will ask them to remove their pockets in group or shake out their clothes for self-searching

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.315 (c). The facility indicated in their response to the PAQ that policy requires that all cross-gender strip searches and cross-gender visual body cavity searches documentation is non-applicable. However, it should be noted that the *Searches for Contraband* policy indicates that if a cross-gender search occurs it will be documented *(p. 5)*. The facility reported in the PAQ that there was no cross-gender strip or cross-gender visual body cavity searches conducted at the facility in the last 12 months. As previously stated, the facility prohibits cross-gender strip or cross-gender visual cavity searches.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.315 (d). As indicated in the PAQ, the facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks, along with policies and procedures that advise staff that Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that, "DYS shall ensure that resident are able to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in incidental circumstances, or in exigent circumstances when such viewing is critical to the safety of the facility" *(p. 4*).

Policy 9.6, *Facility Supervision*, further states that, "Resident under DYS care shall receive awareness supervision at all times with only limited approved exceptions. This supervision may be provided by either male or female employees. When cross-gender supervision takes place, the employee will announce their presence when entering a dorm or an area at times resident are likely to be showering, performing bodily functions, or changing clothing" *(pp.* 2-*3).*

Twelve interviewed staff reported that all staff announce their presence when entering the housing unit does not matter the gender. The staff reported that they will make announcement by saying "staff in dorm or shower area" or simply saying good morning or good evening when entering the area for the first time. Twelve staff stated that residents are able to dress, shower and use the toilet without being viewed by staff or other residents. During the onsite inspection, it was observed that the facility did not have

adequate PREA shower curtains. The shower curtains were long and you could not see the feet of the residents. The facility made corrections, by replacing the shower curtains prior to the completion of the onsite portion of the audit.

Nine of the ten residents stated that staff consistently announce themselves when they come into the dorm area or shower area. One resident stated he did not know if staff announce themselves. All of the residents felt safe and comfortable that staff nor another resident could see them unclothed. Ten residents stated they understood the rules regarding being dressed entering and exiting the bathroom and shower to ensure staff were not able to see them unclothed.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No further corrective action is warranted.

115.315 (e.) Per the PAQ, no searches or physical examination of a transgender or intersex resident for the sole purposes of determining the resident's genital status occurred at the Ft. Bellefontaine facility in the past 12 months. Policy 7.2*, Standards*, states that "the division shall not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's anatomical gender" *(p. 6)*.

Twelve interviewed staff stated that their policy prohibits staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining their genital status. Upon review of the PREA Training Curriculum (*Division of Youth Services Training Guide for physical searches of a resident in a residential setting*), it is further confirmed that the facility does not train on cross-gender searches, or searches on transgender residents to determine genital status.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.315 (f). As reported in the PAQ, the Ft. Bellefontaine facility trained one hundred percent of security-staff on conducting cross-gender pat down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs as such searches are prohibited.

Twelve staff, representing all shifts, working during the audit period were interviewed. The interviewed staff reported that they were trained on pat down searches, however unsure if the training included cross-gender searching. After rephasing the question, all twelve staff did express that they would only conduct cross-gender pat down searches in exigent circumstances and if the safety of others were at risk. All twelve staff stated they would attempt all other options first before conducting a cross gender pat down search to include calling another staff from another building. Twelve staff stated they received pat down searches training during initial on the job training. However, facility has a process that require residents to conduct a search on themselves in a circle. The staff will give directions to youth regarding conducting the personal search.

Upon review of the PREA Training Curriculum (Division of Youth Services Training Guide for physical searches of a resident in a residential setting), it is further confirmed that the facility does not train on cross-gender searches, or searches on transgender residents to determine genital status. A review of a sample of 28 staff training records further supported the Ft. Bellefontaine facility meeting the requirements of the provision. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:
During the onsite inspection, it was observed that the facility did not have adequate PREA shower curtains. The facility made corrections, by replacing the shower curtains prior to the completion of the onsite portion of the audit. There is no further action needed. Standard is found compliant.

Standard 115.316: Residents with disabilities and residents who are limited English proficient

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.316 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) ☒ Yes ☐ No

- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

115.316 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? ☒ Yes ☐ No

- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

115.316 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the

facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

1. Documents:
   a. Pre-Audit Questionnaire (PAQ)
   b. Policy 6.1, *Facility Programmatic Rights of Resident and Grievance Procedures*
   c. Policy 8.3, *Individual Education Facility-Special Education*
   d. Policy 9.18, *Prison Rape Elimination Act (PREA)*
   e. Resident Education Manual (*Safety First*) (Spanish and English)
   f. Resident Grievance Complaint Form
   g. Remote Interpreting Services
   h. Sign Language Interpreter Services
   i. Verbal Language Interpreter Services
   j. PREA Posters (English and Spanish) - 2

2. Interviews:
   a. Manager
   b. Random sample of staff – 12

Findings (By Provision):

115.316 (a). As reported in the PAQ, the Ft. Bellefontaine facility, has established procedures to provide disabled residents equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Policy 6.1, *Facility Programmatic Rights of Resident and Grievance Procedures*, states that resident have a right to "be informed of resident rights, rules, procedures and schedules which have an impact on them. When needed, this will be provided in a manner that is sensitive to limited English proficiency or disability" *(p. 1)*.

Policy 8.3, *Individual Education Facility-Special Education*, states that:

> Resident with disabilities or impairments that significantly limit one or more life functions shall have an equal opportunity to participate in or benefit from all aspects of the DYS facility's efforts to prevent, detect and respond to sexual abuse and sexual harassment. When necessary, to ensure effective communication with resident who are hearing impaired, access to interpreters will be provided who can interpret effectively, accurately and impartially, both receptively and expressively, using any necessary specialized vocabulary. For resident who have intellectual disabilities, limited reading skills or who are visually impaired, DYS shall ensure that written materials are provided in formats or through methods that ensure effective communication, as per Prison Rape Elimination Act (PREA) section 115.316.

The interviewed agency head reported that if the resident goes through the intake facility, the facility will determine the best method to provide residents with all programs at our facilities. "We have contracts with LanguageLines and we have contract for interpreters during education programs. We have contracts with sign languages interpreters in some of our programs and have audio tapes for blind residents. If a resident does not come through the intake facility the intake staff at the arriving facility will notify the facility manager. The facility manager, regional supervisor, community support services will determine the best avenue to provide services with the resident. We also require the same procedure for out Victim Advocate programs."

The facility provided contracts for the following services: remote interpreter services, sign language, and verbal language. The resident handbook (Safety First) is readily available in Spanish and English. During the onsite tour, the auditor observed PREA related signage in Spanish and English.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.316 (b). As reported in the PAQ, the Ft. Bellefontaine facility has established procedures to provide resident with limited English proficiency equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. As previously indicated Policy 8.3, *Individual Education Facility-Special Education*, states that:

> Resident with disabilities or impairments that significantly limit one or more life functions shall have an equal opportunity to participate in or benefit from all aspects of the DYS facility's efforts to prevent, detect and respond to sexual abuse and sexual harassment. When necessary, to ensure effective communication with resident who are hearing impaired, access to interpreters will be provided who can interpret effectively, accurately and impartially, both receptively and expressively, using any necessary specialized vocabulary. For resident who have intellectual disabilities, limited reading skills or who are visually impaired, DYS shall ensure that written materials are provided in formats or through methods that ensure effective communication, as per Prison Rape Elimination Act (PREA) section 115.316.

The facility provided contracts for the following services: remote interpreter services, sign language, and verbal language. The resident handbook (Safety First) is readily available in Spanish and English. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.316 (c). As reported in the PAQ, the Ft. Bellefontaine facility prohibits the use of resident interpreters, readers, or other types of resident assistance and there were zero instances where resident interpreters, readers, or other types of resident assistants have been used. Policy 9.18, *Prison Rape Elimination Act (PREA), "*DYS shall not rely on resident interpreters, readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety" *(p.* 4).

The Ft. Bellefontaine facility reported in the PAQ that there were zero instances in the last 12 months where resident interpreters, readers, or other types of resident assistance was needed. One hundred percent of the random staff interviews reported that resident interpreters are not allowed; nor have resident interpreters, resident readers, or other type of resident assistants used in retaliation to allegations of sexual abuse or sexual harassment.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

Standard 115.317: Hiring and promotion decisions

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.317 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

115.317 (b)

- Does the agency consider any incidents of sexual harassment in determining whether to hire or promote anyone who may have contact with residents? ☒ Yes ☐ No

- Does the agency consider any incidents of sexual harassment in determining whether to enlist the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.317 (c)

- Before hiring new employees, who may have contact with residents, does the agency perform a criminal background records check? ☒ Yes ☐ No

- Before hiring new employees, who may have contact with residents, does the agency consult any child abuse registry maintained by the State or locality in which the employee would work? ☒ Yes ☐ No

- Before hiring new employees who may have contact with residents, does the agency, consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers

for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? ☒ Yes ☐ No

115.317 (d)

- Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No
- Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

115.317 (e)

- Does the agency either conduct criminal background records checks at least every five years of current employees and contractors who may have contact with residents or have in place a system for otherwise capturing such information for current employees? ☒ Yes ☐ No

115.317 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? ☒ Yes ☐ No
- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? ☒ Yes ☐ No
- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? ☒ Yes ☐ No

115.317 (g)

- Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination? ☒ Yes ☐ No

115.317 (h)

- Does the agency provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work? (N/A if providing information on substantiated allegations of sexual abuse or sexual harassment involving a former employee is prohibited by law.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-audit Questionnaire (PAQ)
    b. Policy 9.18, *Prison Rape Elimination Act (PREA)*
    c. Policy 2-107, *Background Checks on Current Employees*
    d. Memo (*Explanation of Background Checks*)
    e. Memo (*Personnel Files*)
    f. DYS Pre-employment reference check
    g. Application for employment
    h. Report of New Charges-3
    i. Annual Background Checks (2018-2020)
2. Interviews:
    a. HR administrator

Findings (By Provision):

115.317 (a). As reported in the PAQ, the Ft. Bellefontaine facility policy prohibits hiring or promoting anyone who may have contact with residents, and prohibits enlisting the services of any contractor who may have contact with residents, who:

1. Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution.
2. Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, of if the victim did not consent or was unable to consent or refuse; or
3. Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a) (2) of this section.

All of the above areas are asked in the pre-employment questionnaire. In which the employee must acknowledge and sign. Policy 9.18, *Prison Rape Elimination Act (PREA),* further reiterates the above requirements. A review of 28 staff, seven contract personnel files; demonstrated that the Ft. Bellefontaine facility is compliant with this policy. The employee records are considered confidential. A memo was provided to the auditor which indicated that five employees were hired in the last 12 months and all of the pre-employment background checks and questions were conducted.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.317 (b). As reported in the PAQ, the Ft. Bellefontaine facility, has a policy that requires the consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with the residents. Policy 9.18, *Prison Rape Elimination Act (PREA),* states that, "DYS shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have with resident" *(p. 5)*. When interviewing the HR administrator, it was further reiterated that the Ft. Bellefontaine facility, has incorporated the above practices in its hiring of staff.

The final analysis of the evidence indicates the facility does consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. The policy provided in the PAQ aligns with the intent of the standard, as well as corroboration by the interviewee. Based on this analysis, the audit finds the facility meets standard.

115.317 (c). The facility indicated in their responses to the Pre-Audit Questionnaire (PAQ) that the facility policies requires that before hiring new employees who may have contact with residents the agency shall: (1) Perform a criminal background records check; and (2) Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

Policy 9.18, *Prison Rape Elimination Act (PREA),* states that:

- DYS shall ensure that a criminal background records check has been completed, and consult applicable child abuse registries, before enlisting the services of any contractor who may have unsupervised contact with resident.
- DYS shall conduct annual criminal background records checks as defined in DSS 2-107 Background Checks on current employees, volunteers/student practicum's, and contractors who may have unsupervised contact with resident.

A statement provided by the PREA coordinator indicated that pre-employment and annual background checks include the following;

- Child abuse/neglect records;
- Child care facility and foster parent licensing records;
- Debts owed to the State for overpayment of public assistance benefits received (Claims Accounting Restitution System);
- Criminal records (open and closed federal and state criminal records);
- Department of Health and Senior Services Employee Disqualification List;
- Department of Mental Health Employee Disqualification Registry;
- Driver's license status;
- Employment history and references;
- Family Care Safety Registry;
- Professional certifications and educational requirements; Sex Offender Registry, and,
- Local criminal and arrest record checks for employees who have access to Federal Tax Information (FTI) (e.g., staff employed in the Family Support Division and Division of Legal Services). This includes a check of county law enforcement agencies where the applicant has lived, worked and/or attended school within the last five years.

An interview with the human resources administrator, indicated that when conducting criminal record background checks consideration is made pertinent to civil or administrative adjudications for all newly

hired employees who may have contact with residents and all employees, who may have contact with residents, who are considered for promotions. Such actions are also taken for contractors. All employers and contractors at Ft. Bellefontaine receive a background and criminal record check annually.

According to the PAQ, in the last 12 months, the facility has hired 23 staff who may have contact with residents who have had criminal background checks completed. A memo was provided to the auditor which indicated that five employees were hired in the last 12 months and all of the pre-employment background checks and questions were conducted.

The final analysis of the evidence indicates the facility requires that before hiring new employees who may have contact with residents, the agency shall: (1) Perform a criminal background records check; (2) Consults any child abuse registry maintained by the State or locality in which the employee would work; and (3) Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. The policy provided aligns with the intent of the standard, as well as corroboration by the interviewee.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.317 (d). The facility indicated in their response to the PAQ that agency policies requires that a criminal background records check is completed before enlisting the services of any contractor who may have contact with residents. Consistent with employee background checks; criminal history background checks, including driver's license checks and fingerprinting, shall be conducted on all volunteers, interns, and persons working in the department on contract who have direct contact with offenders Policy 9.18, *Prison Rape Elimination Act (PREA),* states that:

- DYS shall ensure that a criminal background records check has been completed, and consult applicable child abuse registries, before enlisting the services of any contractor who may have unsupervised contact with resident.
- DYS shall conduct annual criminal background records checks as defined in DSS 2-107 Background Checks on current employees, volunteers/student practicum's, and contractors who may have unsupervised contact with resident.

A statement provided by the PREA coordinator indicated that pre-employment and annual background checks include the following;

- Child abuse/neglect records;
- Child care facility and foster parent licensing records;
- Debts owed to the State for overpayment of public assistance benefits received (Claims Accounting Restitution System);
- Criminal records (open and closed federal and state criminal records);
- Department of Health and Senior Services Employee Disqualification List;
- Department of Mental Health Employee Disqualification Registry;
- Driver's license status;
- Employment history and references;
- Family Care Safety Registry;
- Professional certifications and educational requirements; Sex Offender Registry, and,
- Local criminal and arrest record checks for employees who have access to Federal Tax Information (FTI) (e.g., staff employed in the Family Support Division and Division of Legal

Services). This includes a check of county law enforcement agencies where the applicant has lived, worked and/or attended school within the last five years.

According to the PAQ, in the past 12 months there were seven contracts for services where criminal background record checks were conducted on all staff covered in the contract who may have contact with residents. While the contracted staff provide maintenance services, the facility conducted criminal background checks consistent with direct care staff.

As previously indicated, the interviewed administrative staff reported that the agency performs annual criminal record background checks and considers pertinent civil or administrative adjudications for all newly hired employees who may have contact with residents and all employees, and all employees who are being considered for promotions. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.317 (e). The facility indicated in their responses to the Pre-Audit Questionnaire (PAQ) that the facility either conducts criminal background records checks at least every five years of current employees and contractors who may have contact with residents or has in place a system for otherwise capturing such information for current employees.

DSS Policy 2-107, Background Checks on Current Employees, states that "Criminal Records: An annual check of Missouri open criminal records is conducted on all DSS employees and volunteers. DSS must ensure all identified employees with access to FTI have a reinvestigation of their background check which meets IRS guidelines every ten (10) years" *(p. 3)*.

As previously indicated, the interviewed administrative staff reported that the agency performs annual criminal record background checks and considers pertinent civil or administrative adjudications for all newly hired employees who may have contact with residents and all employees, who are being considered for promotions. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115. 317 (f). The Ft. Bellefontaine facility has all newly hired and promoted employees complete a *Pre-Employee Questionnaire Form*. Policy 9.18, *Prison Rape Elimination Act (PREA),* states that, "DYS shall ask prospective employees and DYS promotional candidates about previous misconduct described in paragraph (a) of this section by requiring them to complete the Department of Social Services (DSS) Employment Application DYS Addendum, in addition to the DSS Employment Application. The division shall also impose upon employees a continuing affirmative duty to disclose any such misconduct as defined in DYS Policy 3.8 Employee Conduct and DSS Policy 2-107 Background Checks" *(p. 6)*.

When interviewing the human resources staff during the on-site audit, it was reported that the background checks are conducted on employees and contractors in accordance with the PREA standards. It was further confirmed that all applicants and employees who have contact with residents are asked about previous misconduct in written applications for hiring or promotions; and there is a continued affirmative duty to disclose any such previous misconduct. Employees are required to report information to DYS human resources unit immediately, but no later than 5 calendar days after the event occurred.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.317 (g). According the to the PAQ, the agency's policy states that material omission regarding misconduct, or the provision of materially false information, shall be grounds for termination. The agency's Policy 9.18, *Prison Rape Elimination Act (PREA),* states that "material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination" *(p. 6)*.

The final analysis of the evidence indicates the facility considers material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. Both the Pre-Employment Questionnaire and facility policies provide evidence to compliance with the standard. Based upon the evidence and analysis, the auditor finds the facility meets standard 115.317 (g).

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.317 (h). The agency's Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that "unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work. Refer to DSS Policy 5-102 (Personnel Records) for further guidance" *(p. 6)*.

The interviewed HR administrator confirmed that the facility will provide information on employment and can provide detailed information on a former employee (s), substantiated allegation of sexual abuse or sexual harassment, upon receiving a request from an institutional employer.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.318: Upgrades to facilities and technologies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.318 (a)

- If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, did the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not acquired a new facility or made a substantial expansion to existing facilities since August 20, 2012, or since the last PREA audit, whichever is later.)
  ☐ Yes ☐ No ☒ NA

115.318 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring

technology since August 20, 2012, or since the last PREA audit, whichever is later.)
☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)

Findings (By Provision):

115.318 (a). N/A-The facility indicated in their responses to the Pre-Audit Questionnaire (PAQ) that the facility has not acquired a new facility or made substantial expansions or modifications to the existing facility since the last PREA audit. When conducting the tour of the facility; the auditor observed that the facility is older and does not appear to have had any modifications or expansions.

The interviewed agency head stated that, "Our number one goal in this agency is to protect residents, staff, and the public. It is paramount that any changes that are considered must take into consideration the effectiveness it will provide to resident and staff. We utilize subject matter experts not only on staffing but in modern technology. The PREA coordinator is at all of the meeting that we have about expansion, modification, contracting and staffing facilities." The interviewed facility manager further reiterated that there have not been any substantial modifications to the facility.

115.318 (b). N/A-The facility reported in the PAQ that they have not installed or updated its video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit. The interviewed facility manager stated that the facility does not have any video monitoring or electronic surveillance system.

Corrective Action:

No corrective action is recommended for this standard.

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.321 (a)

- If the agency is responsible for investigating allegations of sexual abuse, does the agency follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☐ Yes ☐ No ☒ NA

115.321 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☐ Yes ☐ No ☒ NA

- Is this protocol, as appropriate, adapted from or otherwise based on the most recent edition of the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents," or similarly comprehensive and authoritative protocols developed after 2011? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☐ Yes ☐ No ☒ NA

115.321 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? ☒ Yes ☐ No

- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No

- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? ☒ Yes ☐ No

- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

115.321 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? ☒ Yes ☐ No

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? (N/A if the agency *always* makes a victim advocate from a rape crisis center available to victims.) ☐ Yes ☐ No ☒ NA

- Has the agency documented its efforts to secure services from rape crisis centers? ☒ Yes ☐ No

115.321 (e)

- As requested by the victim, does the victim advocate, qualified agency staff member, or qualified community-based organization staff member accompany and support the victim through the forensic medical examination process and investigatory interviews? ☒ Yes ☐ No

- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? ☒ Yes ☐ No

115.321 (f)

- If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating agency follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency/facility is responsible for conducting criminal AND administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

- If the agency uses a qualified agency staff member or a qualified community-based staff member for the purposes of this section, has the individual been screened for appropriateness to serve in this role and received education concerning sexual assault and forensic examination issues in general? (N/A if agency *always* makes a victim advocate from a rape crisis center available to victims.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy 9.18, *Prison Rape Elimination Act (PREA)*
    c. Specialized Training: Medical and Mental Healthcare – 2
    d. Statewide SAFE -CARE Provider Listing for Division of Youth Services-Children's Advocacy Services of Greater St. Louis
    e. Critical Incident Report-3
    f. Investigations-3
    g. External Investigations Correspondence

2. Interviews:
    a. Random sample of staff - 12
    b. PREA compliance manager

Findings (By Provision):

115.321 (a). N/A-The facility indicated in their responses to the Pre-Audit Questionnaire that the agency/facility is not responsible for conducting administrative or criminal sexual abuse investigations. Outside law enforcement will conduct the criminal investigations. Missouri Division of Youth Services does not conduct their own investigations of sexual abuse and harassment. Missouri Children's Division Out of Home Investigation Unit investigates sexual abuse/harassment for DYS regarding residents under the age of 18. Children over the age of 17 are referred to Division of Legal Services Investigation Unit. In cases that are criminal in nature the facility administrator would contact the local law enforcement. In other cases, the Division of Legal Services Investigation Unit would conduct the investigation or notify the local law enforcement and investigate along with the local law enforcement.

Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that, "DYS shall refer all allegations of sexual abuse and sexual harassment to the appropriate investigative agencies based upon the victim's age as defined in DYS Policy 3.8 Employee Conduct. DYS has conveyed the PREA requirements to appropriate external investigating agencies" *(pp. 6-7).*

During the on-site audit, 12 random staff were asked, "Do you know and understand the agency's protocol for obtaining usable physical evidence if a resident alleges sexual abuse?" All of the interviewed staff were aware of the agency's protocols. The staff explained that they would immediately move the resident to a safe location, secure the area, contact supervisor or group leader for next steps. Twelve staff were asked if they know who is responsible for conducting sexual abuse investigations after a report of sexual abuse or sexual harassment has been made. Nine staff stated that facility manager would conduct the investigation. Two staff reported that they were not sure who conducted the investigations, and one staff stated the local law enforcement would conduct investigation.

A review of the appropriate documentation and review of relevant polices indicate that the facility is compliant with the provisions of this standard. No corrective action is warranted.

115.321(b). N/A-the agency/facility is not responsible for conducting any form of criminal or administrative sexual abuse investigations. Missouri Division of Youth Services does not conduct their own investigations of sexual abuse and harassment. Missouri Children's Division Out of Home Investigation Unit investigates sexual abuse/harassment for DYS regarding residents under the age of 18. Children over the age of 17 are referred to Division of Legal Services Investigation Unit. In cases that are criminal in nature the facility administrator would contact the local law enforcement. In other cases, the Division of Legal Services Investigation Unit would conduct the investigation or notify the local law enforcement and investigate along with the local law enforcement.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.321 (c). The facility indicated in their responses to the Pre-Audit Questionnaire that the facility offers all residents who experience sexual abuse access to forensic medical examinations at an outside facility and that there is no charge for these examinations. The facility responded that forensic medical examinations are offered without financial cost to the victim. The facility also indicated that in the past 12 months there were zero forensic medical exams conducted, no exams performed by SANE/SAFEs, nor any exams were performed by a qualified medical practitioner.

Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that:

- DYS shall attempt to make available to the victim a victim advocate from a rape crisis center/child advocacy center. DYS shall document efforts to secure services from rape crisis centers/child advocacy center.
- As requested by the victim, the victim's parent(s)/guardian(s), a victim advocate, or a trained or licensed DYS direct care employee such as a Clinical Coordinator or Regional Psychologist, shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals. Such services shall be documented on the *Critical Incident Review Form* F9-71 *(p. 7)*.

The Ft. Bellefontaine facility has an agreement with Statewide SAFE-CARE Provider, Children's Advocacy Services of Greater St. Louis. The services include sexual assault and forensic examinations, child abuse resource and education. The agreement also indicated that the providers are physicians, nurse practitioners, or physician assistants who are specially trained to provide medical evaluations of children when abuse or neglect is suspected.

A review of the appropriate documentation and review of relevant polices indicate that the facility is compliant with the provisions of this standard. No corrective action is warranted.

115.321 (d). The facility indicated in their responses to the Pre-Audit Questionnaire that it has made attempts to make available to the victim, a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the facility makes available to provide these services a qualified staff member from a community-based organization, or a qualified facility staff member. The facility provided documented efforts to secure services from Children's Advocacy Services of Greater St. Louis.

As previously stated, Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that:

- DYS shall attempt to make available to the victim a victim advocate from a rape crisis center/child advocacy center. DYS shall document efforts to secure services from rape crisis centers/child advocacy center.
- As requested by the victim, the victim's parent(s)/guardian(s), a victim advocate, or a trained or licensed DYS direct care employee such as a Clinical Coordinator or Regional Psychologist, shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals. Such services shall be documented on the *Critical Incident Review Form* F9-71 *(p. 7)*.

The interviewed PREA compliance manager reported that resident can call the state hotline number at any time. The program has an MOU with an advocacy organization to conduct such services. In addition, the residents can receive services with the Children's Advocacy Services of Greater St. Louis Medical Health Center.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.321 (e). The facility indicated in their responses to the Pre-Audit Questionnaire that they would provide, if requested by the victim, a victim advocate, a qualified agency staff member, or a qualified community-based organization staff member to accompany and support the victim through the forensic medical examination process and investigatory interviews and to provide emotional support, crisis intervention, information, and referrals. As previously stated, Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that:

- DYS shall attempt to make available to the victim a victim advocate from a rape crisis center/child advocacy center. DYS shall document efforts to secure services from rape crisis centers/child advocacy center.
- As requested by the victim, the victim's parent(s)/guardian(s), a victim advocate, or a trained or licensed DYS direct care employee such as a Clinical Coordinator or Regional Psychologist, shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals. Such services shall be documented on the *Critical Incident Review Form* F9-71 *(p. 7)*.

Interviews with the PREA compliance manager reported that they will utilize an outside victim services agency. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.321 (f). As indicated in the PAQ the Ft. Bellefontaine Campus facility is not responsible for conducting administrative and criminal investigations; however, the agency has requested that the responsible agency follow the requirements of paragraph 115.321 (a) through (e) of the standards.

There is no further action required for the provision.

115.321 (g). The auditor is not required to audit this section.

115.321 (h). The auditor is not required to audit this section.

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.322: Policies to ensure referrals of allegations for investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.322 (a)

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment? ☒ Yes ☐ No

115.322 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No

- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No

- Does the agency document all such referrals? ☒ Yes ☐ No

115.322 (c)

- If a separate entity is responsible for conducting criminal investigations, does the policy describe the responsibilities of both the agency and the investigating entity? (N/A if the agency/facility is responsible for criminal investigations. See 115.321(a).) ☐ Yes ☐ No ☐ NA

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy 9.18, *Prison Rape Elimination Act (PREA)*
    c. Policy 3.8, *Employee Conduct*
    d. Policy 6.1,
    e. Hotline Report Form
    f. MO DYS Fundamental Practices *(revised 2017)*
    g. Investigations-3
2. Interviews:
    a. Agency head
    b. Investigator - 1

Findings (By Provision):

115.322 (a). The Ft. Bellefontaine facility reported in the PAQ that the facility ensures that administrative and criminal investigations are completed for all allegations of sexual abuse and sexual harassment. Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that, "DYS shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment as defined in DYS Policy 3.8 Employee Conduct and DYS Policy 6.1 Facility Programmatic Rights of Resident and Grievance Process" *(p.7)*. Policy 3.8, *Employee Conduct*, further states that "DYS will work with both entities to remain informed as the investigation progresses and ensure that an administrative or criminal investigation is completed" *(p. 7)*. All staff are required to refer all alleged incidents of sexual abuse, harassment or misconduct to Missouri Children's Division Out-of Home Investigation Unit (CD-OHI) for investigation and determination of child abuse and CD-OHI will contact the appropriate local law enforcement for the determination of criminal charges. For residents over the age of 18 the facility or CD-OHI will contact the Division of Legal Services Investigation Unit. The Legal Services Investigation Unit would conduct the investigation or notify the local law enforcement and investigate along with the local law enforcement. Additionally, all staff refer all allegations of sexual abuse and harassment to the Central Office and complete the *DYS Mandatory Reporting Form*.

The interviewed agency head reported that, "We have several ways for residents to report any allegation of sexual abuse or sexual harassment and we also have several ways for staff to report including mandates on reporting for all staff. Our agency works with Out of Home Investigations and Community Services investigator and with the Law Enforcement official to ensure all allegation are investigated by agencies with legal authority to investigate." All staff are required to refer all alleged incidents of sexual abuse, harassment, or misconduct to Missouri Children's Division Out-of-Home Investigation Unit (CD-OHI) for investigation and determination of child abuse. CD-OHI will contact the appropriate local law enforcement for the determination of criminal charges. For residents over the age of 18 the facility or CD-OHI will contact the Division of Legal Services Investigative Unit. The Legal Services Investigative Unit

would conduct the investigation or notify the local law enforcement and investigate along with the local law enforcement. Additionally, all staff refer all allegations of sexual abuse and harassment to the Central Office and complete the DYS *Mandatory Reporting Form*. The DYS PREA policy and the DYS Fundamental Practices form which describes how investigative responsibilities are handled for allegations of sexual abuse and harassment can be found at the Missouri DYS's website.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.322 (b). As reported in the PAQ, the Ft. Bellefontaine facility has a policy that requires allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that:

- DYS shall refer all allegations of sexual abuse and sexual harassment to the appropriate investigative agencies based upon the victim's age as defined in DYS Policy 3.8 Employee Conduct. DYS has conveyed the PREA requirements to appropriate external investigating agencies.
- When outside agencies investigate sexual abuse and sexual harassment, the DYS shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.

The parent/guardian is provided with the DYS Resident/Parent Handbook (Safety 1st) identifying the zero tolerance to sexual abuse or sexual harassment and the hotline information on how to report. This information is available in both English and Spanish. The interviewed DSS investigator further confirmed that the agency policy requires allegations of sexual abuse or sexual harassment is referred for investigation to the agency that is legally authorized to conduct criminal investigations.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.322 (c). As reported, the Ft. Bellefontaine facility is not responsible for conducting the administrative or criminal investigations.

115.322 (d). The auditor is not required to audit this provision of the standard.

115. 322 (e). The auditor is not required to audit this provision of the standard.

Corrective Action:
No corrective action is recommended for this standard.

TRAINING AND EDUCATION

Standard 115.331: Employee training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.331 (a)

- Does the agency train all employees who may have contact with residents on its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on the right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on the dynamics of sexual abuse and sexual harassment in juvenile facilities? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on the common reactions of juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to avoid inappropriate relationships with residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on relevant laws regarding the applicable age of consent? ☒ Yes ☐ No

115.331 (b)

- Is such training tailored to the unique needs and attributes of residents of juvenile facilities? ☒ Yes ☐ No

- Is such training tailored to the gender of the residents at the employee's facility? ☒ Yes ☐ No

- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No

115.331 (c)

- Have all current employees who may have contact with residents received such training? ☒ Yes ☐ No

- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No

- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

115.331 (d)

- Does the agency document, through employee signature or electronic verification, that employees understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)

b. Policy 9.18, *Prison Rape Elimination Act (PREA)*
c. Policy 3.18, *Training*
d. MO DYS Fundamental Practices (*revised 2017)*
e. Memo: 115.331
f. Staff Training Records-28
g. *Staff PREA Training Module*

2. Interviews:
   a. Random sample of staff – 12
   b. Random sample of residents-10

Findings (By Provision):

115.331 (a). Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that, "DYS will train and/or educate its resident, employees, and onsite service providers in adherence to PREA Standards 115.331 thru 115.333, and 115.335" *(p. 7)*. As reported in the PAQ, the agency trains all employees who may have contact with residents in the following matters:

- The agency's zero-tolerance policy for sexual abuse and sexual harassment;
- How staff fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;
- Residents right to be free from sexual abuse and sexual harassment;
- The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment;
- The dynamics of sexual abuse and sexual harassment in resident facilities;
- The common reactions of sexual abuse and sexual harassment victims;
- How to detect and respond to signs of threatened and actual sexual abuse;
- 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;
- How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.; and
- Relevant laws regarding the applicable age of consent.

The *PREA Staff Training Module* was evaluated by the auditor and contained all items indicated above. The trainings are documented on the employee training logs.

Twelve staff, representing staff from all shifts, were interviewed. Interviews confirmed that each of the staff received PREA education during the initial job training and during annual in-service as well as facility manager or group leader will cover during weekly group meetings. Interviews with staff indicated they are all aware of the Zero Tolerance Policy, employee and resident rights, signs and symptoms of sexual abuse, reporting and responding. Twelve of the direct care staff reported being knowledgeable of the topics they had been trained in. The staff were able to describe the training on zero tolerance, Resident and staff rights, dynamics of sexual abuse and sexual harassment, prevention and response protocol as well supportive services available to residents.

Ten residents interviewed at Ft. Bellefontaine were able to clearly articulate they understood their rights to not be sexually abused or sexually harassed while at the facility. None of the ten Resident reported being sexually abused in the facility. One resident's paperwork stated he had been accused of abuse at another facility. Resident stated they were explained and given information regarding facilities rules against sexual abuse and harassment when they arrived in intake. Each resident was aware of the hotline

number that could be utilized if needed to make a report. In addition, all ten residents felt comfortable telling a staff, group leader or facility manager. Ten residents knew they were not allowed to be punished for reporting sexual abuse or sexual harassment. All ten residents were informed within 48 hours of arrival of their rights and rules against sexual abuse and harassment. During the site inspection, it was continuously visible that resident was able to access PREA posters throughout the facility.

There were no residents interviewed that spoke another primary language or had visual, hearing or other physical disabilities. One resident was on IEP however, no disabilities that caused conflict with comprehending questions during interview.

Through random interviews with 12 staff and review of 28 training records, the auditor confirmed that Ft. Bellefontaine facility staff had been trained on the above defined components. Staff exceed standards and are trained on an annual basis. A review of the appropriate documentation, interviews with appropriate staff and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.331 (b). The facility reported in the PAQ that training is tailored to meet the unique needs and attributes and gender of the residents at the Ft. Bellefontaine facility. The PAQ further states that employees who are reassigned from facilities housing the opposite gender are given additional training. All staff are trained to work with male and female residents.

Ten residents interviewed at Ft. Bellefontaine were able to clearly articulate they understood their rights to not be sexually abused or sexually harassed while at the facility. None of the interviewed residents reported being abused in the facility. One resident's paperwork stated he had been accused of abuse at another facility. The residents stated they were explained and given information regarding facilities rules against sexual abuse and harassment when they arrived in intake. Each resident was aware of the hotline number that could be utilized if needed to make a report. In addition, all ten Resident felt comfortable telling a staff, Group leader or Facility manager. Ten residents knew they were not allowed to be punished for reporting sexual abuse or sexual harassment. All ten residents were informed within 48 hours of arrival of their rights and rules against sexual abuse and harassment. During the site inspection, it was continuously visible that residents were able to access PREA posters throughout the facility.

A review of the appropriate documentation and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.331 (c). The PAQ indicated that 19 of the Ft. Bellefontaine Campus staff currently employed were trained or retrained on the PREA requirements. Refresher training is conducted every year. Training records are documented on staff computerized training files. The training files contain each training provided including the dates, times and duration of training. A memo provided by the PREA coordinator indicated that, "The Division of Youth Services DYS and PREA Staff Training Module is tailored for all genders of resident populations as DYS direct care employees may be hired for a facility housing one gender but during staff shortages will occasionally work in facilities housing resident of the opposite gender. Additionally, some direct care employees work in DYS Day Treatment facilities or the field with all genders of resident". Ten random staff interviews and confirmation from the PCM indicated that as part of the annual training, staff were provided with a PREA informational brochures to keep.

The Ft. Bellefontaine facility provided evidence that refresher training is provided in between annual/bi-annual PREA trainings. A review of the appropriate documentation, interviews with staff, and review of

relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.331 (d). The PAQ indicated that the facility requires employees who may have contact with residents to document, via signature, that they understand the training they received. Refresher training is conducted every year. Training records are documented on staff computerized training files. The training files contain each training provided including the dates, times and duration of training. A pre and post-test will be given to ensure the staff, volunteers, and contractors understand the training received. The center provides a PowerPoint presentation of the training program provided to staff. The PowerPoint presentation provided all of the information noted in the policy. During the pre, on-site, and post-site phase, documentation review of 28 employees indicated acknowledgement of training received. The training records reviewed, provided evidence that the facility consistently conducts annual training with staff, and there was adequate documentation of employee signatures verifying the employee's comprehension of the training.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.332: Volunteer and contractor training

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.332 (a)

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures? ☒ Yes ☐ No

115.332 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)? ☒ Yes ☐ No

115.332 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy 3.18, *Training*
    c. Volunteer/Contract Training Records -7
    d. MO DYS Fundamental Practices *(revised 2017)*
    e. Email: Verifying Background Checks of Contractors
    f. Volunteer (Practicum) and/or Contractual Provider Cover Letter for DYS Fundamental Practices
2. Interviews:
    a. Contractor -1

Findings (By Provision):

115.332 (a). According to the PAQ, all volunteers and contractors who have contact with resident have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse/harassment prevention, detection, and response. Policy 3.18, *Training*, states that, "Supervisor shall review with volunteer/practicum and contractual employee the DYS Fundamental Practices and PREA Cover Memo. The PREA Compliance manager shall maintain a copy of the signed form" *(p. 8)*.

There were seven reported contractors who had indirect contact with the residents in the last 12 months. It should be noted that the reported contractors are maintenance services, which do not have direct contact with the resident. One contracted staff who serves as the facility maintenance worker was interviewed. He stated that he has completed varies trainings during his time with agency that covered PREA. The interview confirmed that he has received PREA education during the initial job training and during annual re-fresher training

It was reported that volunteers and contractors receive the same training as the staff. Additionally, volunteers/interns/contractors receive handouts, brochures and material consistent with staff training and informational material. Due to COVID-19 there were no volunteers authorized to participate at the facility.

115.332 (b). It was reported in the PAQ that there were seven contractors who have contact with residents, who have been trained on the agency's policies and procedures regarding sexual abuse/harassment prevention, detection, and response. Upon review it was identified that the facility has contracted maintenance services. Such services do not have direct contact with the residents, however the facility provided PREA training to the contracted staff.

The interviewed contracted staff stated that he is aware of the Zero Tolerance Policy, employee and resident rights, signs and symptoms of sexual abuse, reporting and responding. However, it was stated that he has limited to no contact with residents. He stated that if he became aware or anything involving sexual abuse, he would inform his supervisor.

115.332 (c). As reported in the PAQ, the Ft. Bellefontaine facility maintains documentation confirming that volunteers/contractors understand the training they have received. The auditor reviewed the training records of seven contracted maintenance staff who have received PREA education along with review of the PREA policy. Said contractors signed attestation statements. The agency requires contractors to sign a statement *Volunteer (Practicum) And/Or Contractual Provider Cover Letter For DYS Fundamental Practices)* of their knowledge and receipt of PREA information.

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.333: Resident education

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.333 (a)

- During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No
- Is this information presented in an age-appropriate fashion? ☒ Yes ☐ No

115.333 (b)

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No
- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Their rights to be free from retaliation for reporting such incidents? ☒ Yes ☐ No
- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.333 (c)

- Have all residents received the comprehensive education referenced in 115.333(b)?

☒ Yes ☐ No

- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility? ☒ Yes ☐ No

115.333 (d)

- Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Are deaf? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills? ☒ Yes ☐ No

115.333 (e)

- Does the agency maintain documentation of resident participation in these education sessions? ☒ Yes ☐ No

115.333 (f)

- In addition to providing such education, does the agency ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the

facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy 9.5, *Resident Care*
    c. Policy 8.3, *Individual Education Facility Special Education*
    d. Resident PREA Education Material (Safety 1st)-19
    e. Memo (*PREA Staff Training and Gender*)
    f. Resident PREA Refresher Training -10
2. Interviews:
    a. Intake staff - 1
    b. Random sample of residents - 10
3. On-site observation
    a. PREA Signage

Findings (By Provision):

115.333 (a). During the intake process resident receive PREA related education in an age-appropriate fashion. Upon the day of arrival, the facility manager will review the Safety 1st handbook with the residents; and the residents will sign receipt of information.

Per the PAQ, 32 residents were admitted during the past 12 months received information at the time of intake of the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or harassment.

One interviewed intake staff reported that during the intake process residents are given PREA information in the resident packet. During the intake meeting resident are given PREA related information in the Resident and Safety 1st packets.

Ten residents interviewed at Ft. Bellefontaine were able to clearly articulate they understood their rights to not be sexually abused or sexually harassed while at the facility. None of the ten residents reported being abused in the facility. One residents' paperwork stated he had been accused of abuse at another facility. The residents stated they were explained and given information regarding facilities rules against sexual abuse and harassment when they arrived in intake. Each resident was aware of the hotline number that could be utilized if needed to make a report. In addition, all ten Resident felt comfortable telling a staff, group leader or facility manager. Ten residents knew they were not allowed to be punished for reporting sexual abuse or sexual harassment. All ten residents were informed within 48 hours of arrival of their rights and rules against sexual abuse and harassment. During the onsite inspection, it was continuously visible that the residents were able to access PREA posters throughout the facility.

There were no residents interviewed that spoke another primary language or had visual, hearing or other physical disabilities. One Resident was on IEP however, no disabilities that caused conflict with comprehending questions during interview. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.333 (b). As reported in the PAQ, 32 residents that were admitted in the facility during the past 12 months, who's length of stay was for 10 days or more received comprehensive education regarding their right to be free from both sexual abuse/harassment and retaliation for reporting such incidents and on agency policies and procedures for responding to such incidents.

The interviewed intake staff reported that during the intake interviews, as part of their Youth Packet (Rights & Responsibilities) Safety 1st Packet, PREA Info posting around the cottage and PREA topics during group meetings. Staff receiving information during trainings and policy updates; and supervisors conduct compliance checks. The facility manager is also responsible for intake.

Ten residents interviewed at Ft. Bellefontaine were able to clearly articulate they understood their rights to not be sexually abused or sexually harassed while at the facility. None of the ten-resident reported being abused in the facility. One resident's paperwork stated he had been accused of abuse at another facility. As previously stated the residents stated they were explained and given information regarding facilities rules against sexual abuse and harassment when they arrived in intake. Each resident was aware of the hotline number that could be utilized if needed to make a report. In addition, all ten Resident felt comfortable telling a staff, group leader or facility manager. Ten residents knew they were not allowed to be punished for reporting sexual abuse or sexual harassment. All ten residents were informed within 48 hours of arrival of their rights and rules against sexual abuse and harassment. During the site inspection, it was continuously visible that resident were able to access PREA posters throughout the facility.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.333 (d). As indicated in the PAQ, resident PREA education is available in formats accessible to all residents, including those that are: limited English proficient (LEP), deaf, visually impaired, otherwise disabled, limited in their reading skills. Policy 8.3, *Individual Education Facility and Special Education*, states that:

> Residents with disabilities or impairments that significantly limit one or more life functions shall have an equal opportunity to participate in or benefit from all aspects of the DYS facility's efforts to prevent, detect and respond to sexual abuse and sexual harassment. When necessary, to ensure effective communication with residents who are hearing impaired, access to interpreters will be provided who can interpret effectively, accurately and impartially, both receptively and expressively, using any necessary specialized vocabulary. For residents who have intellectual disabilities, limited reading skills or who are visually impaired, DYS shall ensure that written materials are provided in formats or through methods that ensure effective communication, as per Prison Rape Elimination Act (PREA) section 115.316 *(p. 2)*.

While conducting the onsite inspection, the auditor observed PREA education in Spanish and English. Additionally, the facility provided a copy of the resident pamphlet in Spanish and English. The facility has a contract with an interpreter service if needed. The resident reported that staff would read the documents to them if they did not understand. There were no residents interviewed that were limited English speaking or that had visual, hearing or other physical disabilities.

A review of the appropriate documentation, interviews with appropriate staff and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action

is warranted. There were no residents who met the criteria of this provision to be interviewed at the time of the audit.

115.333 (e). As reported in the PAQ, the agency maintains documentation of resident participation in the PREA education sessions. Documentation of resident's participation in the PREA comprehensive education sessions is available per policy and facility procedures in the resident files. Resident intake records were reviewed to assure fidelity with this documentation. While the youth reported receiving PREA education, ten of their signed forms were not located. During the onsite audit, the youth were given refresher training on PREA and signed documentation acknowledging receipt. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.333 (f). The facility reported in the PAQ that the agency will ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats. Based on site review, the PREA materials (including posters, resident handbooks, and brochures) were available in both English and Spanish. The residents housed at the facility had ready access to PREA related material. During the site tour PREA related resident education was found throughout the facility.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:
While the youth reported receiving PREA education, ten of their signed forms were not located. During the onsite audit, the youth were given refresher training on PREA and signed documentation acknowledging receipt. There is no further corrective action needed.

Standard 115.334: Specialized training: Investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.334 (a)

- In addition to the general training provided to all employees pursuant to §115.331, does the agency ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)
  ☐ Yes ☐ No ☒ NA

115.334 (b)

- Does this specialized training include techniques for interviewing juvenile sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☐ Yes ☐ No ☒ NA

- Does this specialized training include proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☐ Yes ☐ No ☒ NA

- Does this specialized training include sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☐ Yes ☐ No ☒ NA

- Does this specialized training include the criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)
  ☐ Yes ☐ No ☒ NA

115.334 (c)

- Does the agency maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)
  ☐ Yes ☐ No ☒ NA

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
   a. Pre-Audit Questionnaire (PAQ)
2. Interviews:
   a. Manager – 1
   b. Investigator - 1

Findings (By Provision):

115.334 (a). N/A-As indicated in the PAQ, the agency/facility does not have trained investigators as all PREA related investigations are conducted by an outside entity. The agency does not conduct any sexual abuse investigations.

The interviewed DSS investigator reported that he received training specific to sexual abuse and sexual harassment investigations in confinement settings. It was also reported that all of the DSS agents that conduct sexual abuse investigations have attended the Specialized Training in Investigating Sexual Abuse in Correctional settings from the National PREA Resource Center.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.334 (b). N/A-the agency does not conduct any form of administrative or criminal sexual abuse investigations. However, the auditor spoke with one of the investigators for DSS. The interviewed investigator reported that the training topics included:

- Techniques for interviewing juvenile sexual abuse victims.
- Proper use of Miranda Garrity warnings.
- Sexual abuse evidence collection in confinement settings.
- The criteria and evidence required to substantiate a case administrative or prosecution referral.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.334 (c). N/A-the agency does not conduct any form of administrative or criminal sexual abuse investigations.

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.335: Specialized training: Medical and mental health care

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.335 (a)

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to detect and assess signs of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
  ☒ Yes ☐ No ☐ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

115.335 (b)

- If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations? (N/A if agency medical staff at the facility do not conduct forensic exams *or* the agency does not employ medical staff.) ☒ Yes ☐ No ☐ NA

115.335 (c)

- Does the agency maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

- Do medical and mental health care practitioners contracted by or volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy 9.18, *Prison Rape Elimination Act (PREA)*
    c. Policy 3.18, *Training*
    d. Medical and Mental Health Training Records – 2
    e. Specialized Training-PREA for Nurses
    f. Refresher Training
2. Interviews:
    a. Medical and mental health staff - 2

Findings (By Provision):

115.335 (a). Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that, "DYS will train and/or educate its resident, employees, and onsite service providers in adherence to PREA Standards 115.331 thru 115.333, and 115.335" *(p. 7)*. The Policy 3.18, *Training*, further reiterates that:
Medical and Mental Health Care Providers:

1. DYS employed medical and mental health care providers such as; Register Nurse, License Practical Nurse and Regional Psychologist shall complete training in accordance with sections III B. numbers 2. and 4 of this policy.
2. DYS employed medical providers such as; Register Nurse Senior, Register Nurse and License Practical Nurse shall Complete the Prison Rape Elimination Act (PREA) Medical Health Care for Sexual Assault Victims in a Confinement Setting Course http://nicic.gov/library/027696
3. Contracted medical and mental health care providers who work regularly in DYS facilities shall review and signed the DYS Fundamental Practices and PREA cover memo. The PREA Compliance manager shall maintain a copy of the signed form. The manager may also review DYS facility specific Information to include safety/security requirements with the providers *(pp. 7-8)*

As reported in the PAQ, there is one medical or mental health staff who work regularly at the facility that has received the training required by policy. The auditor reviewed specialized training records for two staff (one mental health/one medical). During the onsite audit, there was one new medical staff; however, she has not completed the required training as of yet. The mentioned staff reported that she has not been given full access to the online training modules.

Two staff representing medical and mental health services were interviewed. One of the interviewed staff were able to provide evidence of training to support their knowledge and understanding to detect sings of sexual abuse, professionally interact with victims, preserve physical evidence, as well as perform health care reporting documentation responsibilities. The 2nd interviewed staff reported that they have not received any training specific to PREA and sexual abuse. The auditor recommended refresher training for the interviewed medical staff. Refresher training was conducted on 5/1/2021.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No further corrective action is warranted.

115.335 (b). N/A-The Ft. Bellefontaine medical staff do not conduct forensic medical examinations. Interviews with the medical and mental health staff, further confirmed that they are not trained to conduct such examinations. Forensic medical examinations would occur at the local hospital (Children's Advocacy Services of Greater St. Louis Medical Healthcare).

A review of the appropriate documentation and review of relevant polices indicate that the facility is compliant with the provisions of this standard. No corrective action is warranted.

115.335 (c). As reported in the PAQ, the facility maintains training records of the medical and mental health staff. A sample of two medical and mental health staff records were reviewed and confirmed that the staff receives training as required by the standard.

A review of the appropriate documentation review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:
Refresher training was recommended for the interviewed medical staff, covering the responsibilities of medical and sexual abuse allegations. The refresher training was completed on 5/1/2021. There are no further corrective actions recommended for the standard.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.341 (a)

- Within 72 hours of the resident's arrival at the facility, does the agency obtain and use information about each resident's personal history and behavior to reduce risk of sexual abuse by or upon a resident? ☒ Yes ☐ No

- Does the agency also obtain this information periodically throughout a resident's confinement? ☒ Yes ☐ No

115.341 (b)

- Are all PREA screening assessments conducted using an objective screening instrument? ☒ Yes ☐ No

115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (1) Prior sexual victimization or abusiveness? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (3) Current charges and offense history? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (4) Age? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (5) Level of emotional and cognitive development? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (6) Physical size and stature? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (7) Mental illness or mental disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (8) Intellectual or developmental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (9) Physical disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (10) The residents' own perception of vulnerability? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? ☒ Yes ☐ No

115.341 (d)

- Is this information ascertained through conversations with the resident during the intake process and medical mental health screenings? ☒ Yes ☐ No

- Is this information ascertained during classification assessments? ☒ Yes ☐ No

- Is this information ascertained by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files? ☒ Yes ☐ No

115.341 (e)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy 9.18, *Prison Rape Elimination Act (PREA)*
    c. Policy 9.5, *Residential Care*
    d. Policy 6.7,
    e. PREA Vulnerability Information Review (PVIR)-23
    f. Intake Form-23
    g. Nurse Assessment-23
    h. Facility Health Screening-23
    i. PVIR Refresher Training (dated 5/3/2021)
    j. Updated PVIRs-2
2. Interviews:
    a. Staff responsible for Risk Screening - 1
    b. Random sample of residents - 10
    c. PREA coordinator
    d. PREA compliance manager

Findings (By Provision):

115.341 (a). As reported in the PAQ, the agency has a process in place to screen and support the residents in care. The Missouri Division of Youth Services utilizes a process where residents go through a reception center prior to their arrival at a facility. Prior to their arrival the facility administrator will receive an overview of the resident's history, mental health needs, family orientation and plan of care. Policy 9.5, *Residential Care*, provides the following guidance:

Residential Pre-Placement Planning

A. Following assessment, the SC shall recommend residential placement to the SC team and/or SC supervisor (SCS).
B. After discussion with the SC team and/or supervisor, a final placement decision is made and the SCS shall ensure the residential facility is contacted and appropriate case file information is provided prior to the resident's arrival.
C. Upon notification that a resident is being assigned to a residential facility, designated residential staff shall ensure receipt and review of case information and complete section A of the PREA *Vulnerability Information Review Form* (PVIR) DYS form F9-72.
D. The SCS shall ensure immediate resident needs are addressed, transportation arrangements made and notification provided to parent(s)/legal guardian(s) for delivery of resident to the residential facility.

Residential Placement

A. Upon a resident's arrival to the assigned residential facility, designated residential employees shall follow intake procedures outlined below:
    a. Complete remaining sections of the *PVIR Form* F9-72
        i. within 72 hours.
    b. Complete and enter the Juvenile Movement Form
B. (DYS: F4-11) in accordance with DYS Administrative Policy 4.2 (On-Line Information Tracking System).

    a. Provide resident with the Resident/Parent Hand Book and review its contents within 72 hours. Every effort will be made to provide a copy of the Resident/Parent Handbook to the parent(s)/legal guardian(s).

b. Complete Safety-First Training. Information within the training regarding safety, rights and how to report shall be completed immediately upon arrival. The remainder of the training shall be completed within 10 days of arrival.
c. Complete Restraint Training in accordance with DYS Administrative Policy 3.18 (Training).
d. Complete Facility Health Screen form DYS: F7-17 in accordance with DYS Administrative Policy 7.2 (Standards).
e. Complete Nursing Assessment in accordance with DYS Administrative Policy 7.2 (Standards).
f. Ensure parent(s)/legal guardian(s) is notified of resident's arrival.
g. Any additional procedures set forth in the facility's facility manual in accordance with DYS Policy 5.12 Establishment and Maintenance of Manuals.

Policy 9.18 further reiterates that "Upon a resident's entry into the facility, intake procedures set forth in DYS Policy 9.5 Residential Care shall be followed" *(p. 8)*.

According to the PAQ, 27 residents who entered the facility within the past 12 months were screened for risk of sexual victimization or risk of sexually abusing residents within 72 hours of their entry into the facility. A review of 23 records of residents who entered the facility in the last 12 months provided evidence that the appropriate screenings occur within 72 hours. There are multiple screening tools utilized. The various forms used are called: Intake Form, Nurse Assessment, PVIR, Health Screening, Facility Health Screening, and Nursing Assessment. One hundred percent of the reviewed intake screening forms were completed within one day; hence exceeding the standards; however, the screening tools were not completed in accordance with instruction therefore information was not accurately documented.

One staff responsible for risk screening was interviewed. The staff reported that upon admission from another facility a risk of sexual abuse victimization or sexual abusiveness is completed. The screening tool (PVIR) is usually completed within 72 hours of admission. The facility manager stated that the information is ascertained by talking with the resident, review of documents and the facility health screen. It was also reported that the reassessments are completed every six months.

Ten residents have been at the facility for less than 12 months. Ten residents stated they were asked about sexual orientation, disabilities and if they felt safe at the facility during intake. Ten residents stated they have not been asked by staff or another resident about their sexual orientation or disabilities since the intake process.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.341 (b). The PAQ indicated that the Ft. Bellefontaine facility utilizes a risk assessment that is an objective screening instrument called a *PREA Vulnerability Information Review Form (PVIR)*. Twenty-three of the forms were reviewed by the auditor. Upon review the auditor noticed that the PVIRs were not completed correctly. The auditor recommended that the facility manager complete a refresher training on how to complete the PVIRs. A review of the appropriate documentation and relevant policies indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.341 (c). The interviewed staff responsible for risks screenings, reported that the tool looks at demographics, whether the person has been a victim or victimized, intake documents, nursing

assessment, facility health screen and the initial health screen. A review of the screening instrument confirmed that the above-mentioned areas are taken into consideration when making facility programming and housing decisions. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.341 (d). The interviewed staff responsible for risk screening, reported that they attain the information through conversation and file review. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.341 (e). Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that "information received during assessment shall be disseminated in accordance with DYS Policy 4.1 Official Case File Requirements and Maintenance" *(p. 8).*

The interviewed PREA coordinator stated that only direct care employees and administrative support employees who enter data and educational records have access. Files are maintained in locked offices or locked file cabinets. The designated PREA compliance manager reported that the direct care staff and clerical staff would have access to the information. The interviewed staff responsible for performing the screening for risk of victimization and abusiveness reported that all staff have limited access to information.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:
Upon review of the PVIRs it was identified that the PVIRs were not being completed according to instruction. The auditor recommended that the facility manager complete a refresher training on how to complete the PVIRs. The refresher training was conducted on 5/3/2021. Additionally, the facility shall provide completed PVIRs, showing proof of corrected completion. Two PVIRs were provided, demonstrating the ability to complete the forms in the correct manner. No further action required.

Standard 115.342: Use of screening information

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.342 (a)

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Facility Assignments? ☒ Yes ☐ No

115.342 (b)

- Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

- During any period of isolation, does the agency always refrain from denying residents any legally required educational facility programming or special education services? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

- Do residents in isolation receive daily visits from a medical or mental health care clinician? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

- Do residents in isolation also have access to other facilitys and work opportunities to the extent possible? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

115.342 (c)

- Does the agency always refrain from placing lesbian, gay, and bisexual (LGB) residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex (LGBTI) identification or status as an indicator or likelihood of being sexually abusive? ☒ Yes ☐ No

115.342 (d)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider, on a case-by-case basis, whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? ☒ Yes ☐ No

- When making housing or other facility assignments for transgender or intersex residents, does the agency consider, on a case-by-case basis, whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems? ☒ Yes ☐ No

115.342 (e)

- Are placement and facility programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident? ☒ Yes ☐ No

115.342 (f)

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and facility programming assignments? ☒ Yes ☐ No

115.342 (g)

- Are transgender and intersex residents given the opportunity to shower separately from other residents? ☒ Yes ☐ No

115.342 (h)

- If a resident is isolated pursuant to provision (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

- If a resident is isolated pursuant to provision (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

115.342 (i)

- In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy 9.18, *Prison Rape Elimination Act (PREA)*
    c. Policy 9.8, *Separation*
    d. Policy 6.1, Facility Programmatic Rights of Youth and Grievance Process
    e. Policy 6.7, *Administrative Review*
    f. PREA Vulnerability Information Review (PVIR)-23
    g. PVIR Refresher Training (dated 5/3/2021)
2. Interviews:
    a. PREA compliance manager
    b. PREA coordinator
    c. Staff responsible for Risk Screening - 1
    d. Manager
    e. Medical and mental health staff - 2
    f. Randomly selected staff – 12
    g. Updated PVIRs-2
3. Onsite Tour
    a. Review of housing units

Findings (By Provision):

115.342 (a). As stated in the PAQ, the Ft. Bellefontaine Campus facility, uses information from the risk screening to inform housing, bed, work, education, and facility assignment with the goal of keeping the resident safe and free from sexual abuse. Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that "DYS shall use information obtained during the comprehensive assessment and facility intake procedures to make placement decisions with the goal of keeping all resident safe and free from sexual abuse. Placement decisions regarding identified lesbian, gay, bisexual, transgender, or intersex resident shall not be made solely on the basis of such identification or status" *(p. 8)*.

The interviewed PREA compliance manager/designated staff responsible for risk screening indicated that facility would use the information from the screening to inform housing and safety of the youth. For example we would not put a victim and a perpetrator near each other.

Upon review of the PVIRs it was identified that the PVIRs were not being completed according to instruction. The auditor recommended that the facility manager complete a refresher training on how to complete the PVIRs. The refresher training was conducted on 5/3/2021. Additionally, the facility shall provide two months of documented completed PVIRs; showing proof of corrected completion.

115.342 (b). As stated in the PAQ, the Ft. Bellefontaine Campus facility, has a policy that indicates that the residents at risk of sexual victimization will only be placed in isolation if less restrictive measures are inadequate to keeping them and other residents safe. The facility further reported that if placed in isolation the resident will have access to legally required educational facility programming, special education services, and daily large-muscle exercise. The Ft. Bellefontaine facility reported in the PAQ that zero residents at risk of sexual victimization were placed in isolation in the past 12 months.

Policy 9.8, *Separation*, states that, "The Division of Youth Services (DYS) may utilize separation, but only as a last resort in those extreme instances when the safety of the resident and others cannot be met through other treatment and crisis intervention strategies" *(p. 1)*.

The same policy further elaborates that, when a resident is separated Minimal standards for conditions in accordance with 211.343 RSMO and the Missouri Supreme Court Rules and Standards for the Operation of Juvenile Detention Facilities shall include, but not be limited to:

a. The resident shall be provided adequate bedding for use during normal sleeping hours which shall be removed for the remainder of the day.
b. The resident shall have the opportunity to shower once each day and shall be provided adequate personal hygiene articles.
c. The resident shall be entitled to a minimum of one hour per day recreation outside the separation room.
d. Attempts shall be made daily to provide the resident with educational materials which will allow the resident to remain current with his/her educational facility.
e. Non-academic reading material shall be made available to the resident.
f. The resident shall have the opportunity for three meals daily.
g. The resident shall have the opportunity to wear appropriate clothing for the season.

The manager also confirmed that the facility does not use isolation. The interviewed mental health and medical staff reported that isolation is not used at the facility. It should be noted that there were no identified residents placed in isolation who were at risk of sexual victimization. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.342 (c). As reported in the PAQ, the facility prohibits placing lesbian, gay, bisexual, or intersex residents in particular housing, bed, or other assignments solely on the basis of such identification status. The PAQ further reiterates that the facility prohibits considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that, "Placement decisions regarding identified lesbian, gay, bisexual, transgender, or intersex resident shall not be made solely on the basis of such identification or status" *(p. 8)*. Policy 6.1, *Facility Programmatic Rights of Resident and Grievance Process*, states that "resident have the right to "Not be discriminated against because of race, color, national origin, ancestry, sex, sexual orientation, gender identity, disability or religion" *(p. 1)*.

The interviewed PREA coordinator reported that it would be handled on a case-by case basis for each facility. "Placement for each case is determined on a case-by-case basis, staff with central office and

regional leadership". The interviewed PREA compliance manager reported that the facility does not have special housing unit (s) for lesbian, gay, bisexual, transgender or intersex residents. There were no residents interviewed that identified as lesbian, gay, or bisexual.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.342 (d). As reported in the PAQ, the facility makes housing and facility assignments for transgender or intersex residents in a facility on a case-by-case basis. As previously stated, the facility policy will make assignment decisions for transgender or intersex residents on a case by case. The agency policy does not delineate placement based on sexual orientation. All residents are reviewed and assessed the same no matter their sexual orientation.

The interviewed PREA compliance manager/staff responsible for risk screening stated that they would assess each situation based on the individuals on a case-by-case basis. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.342 (e). As previously stated, the residents in the program are treated the same no matter the sexual orientation. All resident's needs are assessed on a case-by-case basis to determine housing and program decisions.

The interviewed staff responsible for risk screening stated that safety considerations are made for transgender or intersex residents and would be taken into consideration. The interviewed PREA compliance manager stated that the facility will take into consideration and assess for safety; safety is at the forefront of what we do as an agency. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.342 (f). Policy & Procedures, indicates that all residents shall have an administrative case review every six months. An administrative case review is "a formal review which evaluates the treatment progress, placement, and quality of services and offers recommendations as deemed appropriate" *(p. 1)*.

The interviewed PREA compliance manager/staff responsible for risk screening reported that the Ft. Bellefontaine staff shall take into consideration a transgender or intersex resident's own view with respect to his or her own safety. It was also reported that the facility has never had a transgender or intersex resident.

The interviewed staff responsible for screening stated that they have not had any transgender or intersex residents; however, their views for their own safety would be taken into consideration. All residents shower alone. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.342 (f). Policy & Procedures, indicates that all residents shall have an administrative case review every six months. An administrative case review is "a formal review which evaluates the treatment progress, placement, and quality of services and offers recommendations as deemed appropriate" *(p. 1)*.

The interviewed PREA compliance manager/staff responsible for risk screening reported that the Ft. Bellefontaine staff shall take into consideration a transgender or intersex resident's own view with respect to his or her own safety.

The interviewed staff responsible for screening stated that they have not had any transgender or intersex residents; however, their views for their own safety would be taken into consideration. All residents shower alone. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.342 (h). The PAQ, indicated that there were zero residents at risk of sexual victimization who were held in isolation in the past 12 months. As reported by the PREA compliance manager there were no residents placed in isolation that were at risk for sexual victimization.

115.342 (i). Ft. Bellefontaine does not utilize isolation; however, Policy 9.8, Separation, "In the event a resident remains in separation for 12 hours or the separation will extend into the resident's bedtime, the site supervisor shall ensure that the parent(s)/legal guardian(s), ARA, RA, supervising Deputy Director and all other parties involved in the resident's treatment are convened to determine interventions and possible actions" *(p. 2)*.

All random interviewed staff could be responsible for supervising residents in isolation; however, none were aware of an instance of residents being placed in isolation that were at risk for sexual victimization. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:
Upon review of the PVIRs it was identified that the PVIRs were not being completed according to instruction. The auditor recommended that the facility manager complete a refresher training on how to complete the PVIRs. The refresher training was conducted on 5/3/2021. Additionally, the facility shall provide completed PVIRs, showing proof of corrected completion. Two PVIRs were provided, demonstrating the ability to complete the forms in the correct manner. No further action required.

REPORTING

Standard 115.351: Resident reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.351 (a)

- Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Retaliation by other residents or staff for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency provide multiple internal ways for residents to privately report: Staff neglect or violation of responsibilities that may have contributed to such incidents? ☒ Yes ☐ No

115.351 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No
- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No
- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment? (N/A if the facility *never* houses residents detained solely for civil immigration purposes.) ☒ Yes ☐ No ☐ NA

115.351 (c)

- Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties? ☒ Yes ☐ No
- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.351 (d)

- Does the facility provide residents with access to tools necessary to make a written report? ☒ Yes ☐ No
- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
   a. Pre-Audit Questionnaire (PAQ)
   b. Policy 9.18, *Prison Rape Elimination Act (PREA)*
   c. Policy 6.1, *Facility Programmatic Rights*
   d. Policy 3.8, *Employee Conduct*
   e. DSS Policy 2-101 Sexual Harassment/Inappropriate Conduct
   f. Resident PREA Education Material (Safety 1st)-23
   g. PREA Poster
   h. Reporting to External Entity Statement
   i. MO Mandated Reporting Statute
   j. MO DYS Fundamental Practices
2. Interviews:
   a. Random sample of staff -12
   b. Random sample of residents-10

Findings (By Provision):

115.351 (a). As reported in the PAQ, the Ft. Bellefontaine facility has established procedures allowing multiple internal ways for residents to privately report sexual abuse or sexual harassment. Policy 9.18, *Prison Rape Elimination Act (PREA)*, "DYS shall provide multiple internal ways for resident to privately report sexual abuse and sexual harassment, retaliation by other residents or employees for reporting sexual abuse and sexual harassment, and employee neglect or violation of responsibilities that may have contributed to such incidents in accordance with DYS Policy 6.1 Facility Programmatic Right of Resident and Grievance Process" *(p.* 9). Policy 6.1, *Facility Programmatic Rights*, further elaborates that resident have a right to "report any problems or complaints and have those complaints investigated without any fear of punishment or retaliation" *(p. 2)*.

In review of the student handbook, there are multiple ways provided for the residents to report sexual abuse or sexual harassment. Additionally, the facility provided copies of the Ft. Bellefontaine grievance

forms. The grievance process is one of many ways in which a resident could report sexual abuse or sexual harassment. During the tour of the facility the auditor observed PREA posters throughout the facility.

The twelve interviewed random sample of staff reported that the residents can report by using the hotline number, notify staff, group leader, parent or complete grievance process. All twelve staff did report that if youth made a call the number would be dialed and placed on speakerphone. All the interviewed staff reported that if a residents makes a report verbally or in writing, sexual abuse or harassment, the allegations are responded to immediately and they would immediately contact supervisor

Ten residents understood and felt comfortable telling staff, group leader or facility manager if they needed to report sexual abuse or sexual harassment for themselves or another resident. Three residents stated they would use the PREA hotline number. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.351 (b). As reported in the PAQ, the Ft. Bellefontaine facility provides more than one way for residents to report abuse or harassment to a public or private entity that is not part of the agency. The PAQ further states that it is not applicable for the agency to have a policy requiring residents detained solely for civil immigration purposes be provided information on how to contact relevant consular officials and relevant officials of the Department of Homeland Security.

Review of the *Safety 1st packet*, further confirmed residents are provided multiple ways in which they can make a report of sexual abuse and sexual harassment. Such ways to report also included to a public or private entity that is not a part of the agency.

All of interviewed residents stated that they had multiple ways to report. Five residents knew they did not have to give their names on the PREA hotline however did not know if they completed a grievance they did not have to disclose their names. The PREA compliance manager further reiterated that residents could report allegations of sexual abuse or sexual harassment by calling the abuse hotline. While the residents have access to a phone, they have to ask permission first to use it.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.351 (c). The facility reported in the PAQ, that there is a policy mandating staff to accept reports of sexual abuse or sexual harassment made verbally, in writing, anonymously and from third parties. Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that, “DYS employee are required to accept all reports of this nature to include those made verbally, in writing, anonymously, and from third parties. Verbal reports shall be documented. The documentation of verbal reports shall be maintained by the PREA Compliance manager” *(p. 9)*.

The student orientation handbook describes multiple means for residents to report. Such means include verbally, in writing, anonymously, and from third parties. As previously discussed, the residents were able to describe being able to make reports verbally, in writing, anonymously, and from third parties.

The interviewed random sample of staff reported that the residents are allowed to make report verbally or written by telling a staff, group leader or facility manager if they needed to report sexual abuse or sexual harassment for themselves or another resident. Twelve staff also understood they are mandated reporter and expected to report this information immediately to supervisor or the PREA Hotline number.

The staff stated that the youth are able to report abuse or sexual harassment directly to PREA Hotline number as well. Residents would have to ask a staff member to use the phone.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.351 (d). As reported in the PAQ, the facility provides residents with access to tools to make written reports of sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.

The PCM reported that the facility provides residents with tools to help them make written reports of sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment. Such reports could be made by completing a grievance form, access to a pen and paper, family and/or the service coordinator. All ten interviewed residents stated they have never told anyone at facility that they were sexually abused or sexually harassed while at the facility.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.351 (e). The facility indicated in their response to the Pre-Audit Questionnaire that the agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents. There are several agency policies that govern this section of the standard.

- Policy 9.18, *Prison Rape Elimination Act (PREA)*- DYS shall require all employees to respond and report immediately in accordance with DYS Policy 3.8 Employee Conduct, any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in any residential/detention facility; retaliation against resident or employee who reported such an incident; and any employee neglect or violation of responsibilities that may have contributed to an incident or retaliation.
- Policy 3.8, *Employee Conduct*- If an employee has reasonable cause to suspect an abusive or neglectful incident has occurred, or if allegations of abuse or neglect have been made, the following shall occur;
    - For resident under the age of 18, the employee shall call the Children's Division (CD) Child Abuse and Neglect Hotline (1-800-392-3738) immediately.
    - For resident over the age of 18, a report shall be made to the Division HR Manager or Personnel Officer who shall refer the allegations to the Division of Legal Services for investigation. In the event that the incident happens after normal business hours or on the weekend, the site supervisor or designee should take immediate action to ensure safety and report immediately the next business day.
    - After the report has been made, the employee should notify their site supervisor who shall immediately notify the RA or designee. In instances wherein the supervisor or designee is believed to be the perpetrator, the employee shall notify the supervisor or designee at the next appropriate supervisory level.
    - DYS will work with both entities to remain informed as the investigation progress and ensure that an administrative or criminal investigation is completed *(p.7)*.
    - Policy 2-101 *Sexual Harassment/Inappropriate Conduct*- Supervisors and managers who receive reports of sexually harassing/ inappropriate conduct or who personally witness such conduct by or of DSS employees must immediately contact their divisional personnel officers to report the allegations, regardless of whether the employee involved wishes to

file a grievance. Failure to immediately report sexually harassing/inappropriate conduct allegations may result in disciplinary action. All allegations must be held in strict Administrative Policy Subject: Sexual Harassment/Inappropriate Conduct Section: 1 – Employment Practices Adm: 2-101 Issued: 12/19/86 Revised: 3/1/99 Page 4 of 4 confidence and not discussed with anyone without a business-related need to know. Personnel officers are responsible for immediately reporting all allegations of sexually harassing/inappropriate conduct to HRC *(pp. 3-4).*

The twelve interviewed staff reported that they could privately report by using the hotline number and they felt comfortable telling supervisor if abuse or harassment did not involve them. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

Standard 115.352: Exhaustion of administrative remedies

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.352 (a)

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of explicit policy, the agency does not have an administrative remedies process to address sexual abuse. ☒ Yes ☐ No

115.352 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.). ☐ Yes ☐ No ☒ NA

- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (g)

- If the agency disciplines a resident for filing a grievance related to alleged sexual abuse, does it do so ONLY where the agency demonstrates that the resident filed the grievance in bad faith? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the

auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy 6.1, *Programmatic Rights and Youth Grievances*
    c. *Grievance Form* (Blank)

Findings (By Provision):

115.352 (a). As reported in the PAQ, the agency does not have an administrative process for dealing with resident grievances regarding sexual abuse and is not exempt from this standard.

115.352 (b). N/A the agency/facility does not have an administrative process for dealing with resident grievances regarding sexual abuse.

115.352 (c). N/A the agency/facility does not have an administrative process for dealing with resident grievances regarding sexual abuse.

115.352 (d). N/A the agency/facility does not have an administrative process for dealing with resident grievances regarding sexual abuse. The agency PREA coordinator reported that while youth can make an allegation on a grievance, the allegation must be immediately reported through the hotline. The agency does not use the grievance process to respond to allegations of sexual abuse and sexual harassment.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.352 (e). N/A the agency/facility does not have an administrative process for dealing with resident grievances regarding sexual abuse.

115.352 (f). N/A the agency/facility does not have an administrative process for dealing with resident grievances regarding sexual abuse.

115.352 (g). N/A the agency/facility does not have an administrative process for dealing with resident grievances regarding sexual abuse.

Corrective Action:

No corrective action is recommended for this standard.

Standard 115.353: Resident access to outside confidential support services and legal representation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.353 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making accessible mailing

addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No

- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? (N/A if the facility *never* has persons detained solely for civil immigration purposes.) ☐ Yes ☐ No ☒ NA

- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.353 (b)

- Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws? ☒ Yes ☐ No

115.353 (c)

- Does the agency maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide residents with confidential emotional support services related to sexual abuse? ☒ Yes ☐ No

- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☒ Yes ☐ No

115.353 (d)

- Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation? ☒ Yes ☐ No

- Does the facility provide residents with reasonable access to parents or legal guardians? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the

facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy 9.18, *Prison Rape Elimination Act (PREA*
    c. Policy 6.2, *Legal Representation*
    d. Poster (information on advocacy and emotional support)
    e. Safety 1st brochure-23
    f. MOA-Preferred Family Healthcare DBA Bridgeway Behavioral Health
2. Interviews:
    a. Random sample of residents - 10
    b. Manager
    c. PREA compliance manager

Findings (By Provision):

115.353 (a). As reported in the PAQ, The Ft. Bellefontaine facility provides residents with access to an outside victim advocate for emotional supportive services related to sexual abuse. Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that, "DYS shall provide resident in DYS residential placement with access to outside victim advocates for emotional support services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll free hotline numbers where available, of local, state, or national victim advocacy or rape crisis organizations. DYS shall allow reasonable communication between resident and these organizations and agencies, in as confidential a manner as possible" *(pp. 9-10*).

The agency has made attempts to establish MOUs with a child advocacy program. One of the programs accessible to the facility is Bridgeway Behavioral Health. The MOU indicates that Bridgeway Behavioral Health can provide residents with access to a victim advocate for emotional support. The Ft. Bellefontaine facility provided a copy of 23 signed *Safety 1st* forms. The forms provided an additional acknowledgement of receipt of the student handbook and additional PREA related materials. During the onsite tour, the auditor observed handouts posted on the resident board that provided information on victim advocacy and emotional support services.

Ten residents were unable to identify any sexual abuse services available outside of the facility. All residents were able to identify the behavioral health notebook that has services available that was in several places throughout the facility. Ten residents acknowledged that they did received information booklet when arrived and know how to access if needed to report sexual abuse or sexual harassment.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.353 (b). Policy 9.18, *Prison Rape Elimination Act (PREA)*, DYS shall inform resident, prior to giving them access, of the extent to which such communications will be monitored as detailed in DYS Policy 6.5 Resident's Visits, Mail and Telephone Privileges and reported in accordance with mandatory reporting laws" *(p. 10*).

When residents were asked, "Do you think the conversations with people from these services would be told to or listened to by someone else?" Ten residents stated that all calls are monitored by staff with

phone on speaker phone. The staff are required to dial the numbers for residents. Ten residents felt they could request privacy from group leader if they needed to make a report about sexual abuse or sexual harassment.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.353 (c). As reported in the PAQ, the agency or facility maintains memoranda of understanding or other agency agreements with community service providers that are able to provide residents with emotional support services related to sexual abuse. Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that, "DYS shall maintain or attempt to enter into memoranda of understanding or other agreements with community service providers that are able to provide resident with confidential emotional support services related to sexual abuse. The PREA Compliance manager shall maintain copies of agreements or documentation showing attempts to enter into such agreements" *(pp. 10).*

The agency has made attempts to establish MOUs with a child advocacy program. One of the programs accessible to the facility is Bridgeway Behavioral Health. The MOU indicates that Bridgeway Behavioral Health can provide residents with access to a victim advocate for emotional support. Additionally, the agency has a cooperative agreement with the Children's Advocacy Services of Greater St. Louis; for forensic and victim advocacy related services. The Ft. Bellefontaine facility provided a copy of 23 signed *Safety 1st* forms. The forms provided an additional acknowledgement of receipt of the student handbook and additional PREA related materials. During the onsite tour, the auditor observed handouts posted on the resident board that provided information on victim advocacy and emotional support services.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.353 (d). As reported in the PAQ, the facility provides residents with reasonable and confidential access to their attorneys or other legal representation, and parents or legal guardians. Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that, "DYS shall provide resident with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parent(s) or legal guardian(s) in accordance with DYS Policy 6.2 Legal Representation and DYS Policy 6.5 Resident's Visits, Mail and Telephone Privileges" *(pp.10).*

The interviewed manager reported that students are able to have reasonable and confidential access to their attorneys or legal representation through phone and mail access if needed. The case managers will set up the phone call, and if requested a private office can be set up. Residents are allowed calls to guardians from their dorms or with the case manager. Residents have access to the minimal of one five-minute phone calls per week to family.

The interviewed PREA compliance manager/facility manager reported that residents can talk to their legal representation at any time as outlined in policy. Ten residents knew they were allowed to contact lawyers in private however none of the residents had contact with a lawyer while in the facility. Ten residents stated they are allowed to speak with parents several times a week. Due to Covid 19 visitation restrictions, residents have been unable to have in person visitation. During close out meeting, suggestions were made to ensure students are given opportunities to speak in private and a method to disclose abuse with having to contact staff.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.354: Third-party reporting

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.354 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.
The following evidence was analyzed in making compliance determination:

1. Documents:
    a. PREA Brochure (Safety 1st)
    b. Posters

Findings (By Provision):
115.354 (a). As reported in the PAQ, the facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment, and the agency/facility publicly distributes information on how to report resident sexual abuse or sexual harassment on behalf of residents. The resident handbook and PREA Brochure (Safety 1st) provides residents with ways to make a report. In addition, the parents are provided a handbook with PREA related information. The agency website (http://dss.mo.gov/dys/) allows for the public to report resident sexual abuse or harassment or a report can be made through the Children's Division Hotline.

The manager reported that there were no third-party reports of sexual abuse or sexual harassment. A review of the appropriate documentation and relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:
No corrective action is recommended for this standard.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.361 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

115.361 (b)

- Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws? ☒ Yes ☐ No

115.361 (c)

- Apart from reporting to designated supervisors or officials and designated State or local services agencies, are staff prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions? ☒ Yes ☐ No

115.361 (d)

- Are medical and mental health practitioners required to report sexual abuse to designated supervisors and officials pursuant to paragraph (a) of this section as well as to the designated State or local services agency where required by mandatory reporting laws? ☒ Yes ☐ No

- Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

115.361 (e)

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office? ☒ Yes ☐ No

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified? ☒ Yes ☐ No

- If an alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? ☒ Yes ☐ No

- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation? ☒ Yes ☐ No

115.361 (f)

- Does the facility report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy 9.18, *Prison Rape Elimination Act (PREA)*
    c. Policy 3.8, *Employee Conduct*
    d. Policy 2-101, *Sexual Harassment/Inappropriate Conduct*
    e. Staff PREA Training Module
2. Interviews:
    a. Random sample of staff -12
    b. Medical and mental health staff - 2
    c. Manager-1

d. PREA compliance manager

Findings (By Provision):

115.361 (a). As reported in the PAQ, the agency requires all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency. Policy 3.8, *Employee Conduct* states that:

> Employees are required to report suspicious or inappropriate conduct of other employees. Whenever a DYS employee has reasonable cause to suspect an abusive or neglectful incident has occurred, they should report immediately as outlined below. This includes, but is not limited to, any knowledge, suspicion or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in any residential/detention facility, even if external to DYS; any retaliation against resident or employee for having reported such an incident; and any employee neglect or violation of responsibilities that may have contributed to an incident or retaliation. All allegations of sexual abuse and harassment, including third-party and anonymous reports, must be investigated *(p.6)*.

Additionally, the agency has policy that require all staff to comply with applicable mandatory child abuse reporting laws. Policy 2-101 *Sexual Harassment/Inappropriate Conduct* states that, "Supervisors and managers who receive reports of sexually harassing/ inappropriate conduct or who personally witness such conduct by or of DSS employees must immediately contact their divisional personnel officers to report the allegations, regardless of whether the employee involved wishes to file a grievance. Failure to immediately report sexually harassing/inappropriate conduct allegations may result in disciplinary action" *(p. 13).*

The twelve staff interviews indicated a clear understanding of the duty to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility. Twelve staff was able to articulate that they were mandated reporters and any knowledge or suspicion of incident would have to be reported immediately. Twelve staff understood retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident of retaliation immediately. The various ways staff indicated that they could make a report included, but was not limited to:

- Report to supervisor
- Report to the PREA Hotline

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.361 (b). As reported in the PAQ, the Ft. Bellefontaine Campus facility requires that all staff comply with any applicable mandatory child abuse reporting laws. Policy 3.8, *Employee Conduct* states that:
If an employee has reasonable cause to suspect an abusive or neglectful incident has occurred, or if allegations of abuse or neglect have been made, the following shall occur;

a. For resident under the age of 18, the employee shall call the Children's Division (CD) Child Abuse and Neglect Hotline (1-800-392-3738) immediately.
b. For resident over the age of 18, a report shall be made to the Division HR Manager or Personnel Officer who shall refer the allegations to the Division of Legal Services for investigation. In the

event that the incident happens after normal business hours or on the weekend, the site supervisor or designee should take immediate action to ensure safety and report immediately the next business day.

c. After the report has been made, the employee should notify their site supervisor who shall immediately notify the RA or designee. In instances wherein the supervisor or designee is believed to be the perpetrator, the employee shall notify the supervisor or designee at the next appropriate supervisory level.
d. DYS will work with both entities to remain informed as the investigation progresses and ensure that an administrative or criminal investigation is completed.

The 12 interviewed random staff reported receiving training on applicable mandatory child abuse reporting laws. Interviews confirmed that each of the staff received PREA education during the initial job training and during annual in-service as well as facility manager or group leader will cover during weekly group meetings. Interviews with staff indicated they are all aware of the Zero Tolerance Policy, employee and resident rights, signs and symptoms of sexual abuse, reporting and responding. Twelve of the direct care staff reported being knowledgeable of the topics they had been trained in. The staff were able to describe the training on zero tolerance, resident and staff rights, dynamics of sexual abuse and sexual harassment, prevention and response protocol as well supportive services available to residents.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.361 (c). As reported in the PAQ, apart from reporting to the designated supervisors or officials and designated State or local service agencies, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. Policy 2-101, *Sexual Harassment/Inappropriate Conduct*, states that, "All allegations must be held in strict Administrative Policy Subject: Sexual Harassment/Inappropriate Conduct Section: 1 – Employment Practices Adm: 2-101 Issued: 12/19/86 Revised: 3/1/99 Page 4 of 4 confidence and not discussed with anyone without a business-related need to know. Personnel officers are responsible for immediately reporting all allegations of sexually harassing/inappropriate conduct to HRC." *(pp. 3-4)*.

The 12 interviewed staff consistently described a process for reporting any information related to sexual abuse incidents as: report immediately, separate residents, close off the area of the incident, do not allow the resident to bath, shower, or brush teeth.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.361 (d). As previously stated, Policy 3.8 *Employee Conduct*, states that all DYS employees are required to accept all reports of allegations of sexual abuse and sexual harassment *(p. 9)*.

The interviewed medical and mental health staff all reported that upon admission/intake residents are notified regarding the limitations of confidentiality and the staff duty to report. It was also reported that the parents sign a limitation of confidentiality form. All of the medical and mental health staff stated that they are required to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment to a designated supervisor or official immediately upon learning of it. One interviewed staff stated that they have had to make a report before and a second stated that the incident

was already reported. It should be noted that the medical and mental health staff are responsible for multiple facilities on the Missouri Hills campus.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.361 (e). Policy 3.8, *Employee Conduct* states that:
If an employee has reasonable cause to suspect an abusive or neglectful incident has occurred, or if allegations of abuse or neglect have been made, the following shall occur;

a. For youth under the age of 18, the employee shall call the Children's Division (CD) Child Abuse and Neglect Hotline (1-800-392-3738) immediately.
b. For youth over the age of 18, a report shall be made to the Division HR Manager or Personnel Officer who shall refer the allegations to the Division of Legal Services for investigation. In the event that the incident happens after normal business hours or on the weekend, the site supervisor or designee should take immediate action to ensure safety and report immediately the next business day.
c. After the report has been made, the employee should notify their site supervisor who shall immediately notify the RA or designee. In instances wherein the supervisor or designee is believed to be the perpetrator, the employee shall notify the supervisor or designee at the next appropriate supervisory level.
d. DYS will work with both entities to remain informed as the investigation progresses and ensure that an administrative or criminal investigation is completed.

The interviewed manager/PCM stated that when they receive an allegation of sexual abuse it will be immediately reported to the appropriate parties. The report is made through the hotline to investigations. They would notify the Children Division within 24 hours. If the youth is under the guardianship of the child welfare system, they would notify the caseworker "right away".

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.361 (f). As previously stated, all DYS employees are required to report allegations of sexual abuse or sexual harassment. The allegations of sexual abuse and sexual harassment, including third-party and anonymous reports to the Children's Division of Out of Home Investigations or Division of Legal Services if the resident is 18 or over.

The interviewed manager reported that all allegations of sexual abuse and sexual harassment are directly reported to the abuse hotline, direct supervisor, parent/guardian, and the service coordinator. If the resident is under the guardianship of the child welfare system, it would be reported to the Children's Division. It should be noted that all allegations of sexual abuse or sexual harassment are reported immediately to the Children's Division for minors.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.362: Agency protection duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.362 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-audit Questionnaire (PAQ)
    b. Policy 9.18, *Prison Rape Elimination Act (PREA)*
2. Interviews:
    a. Agency head
    b. Manager
    c. Random sample of staff - 12

Findings (By Provision):

115.362 (a). As reported in the PAQ, there were zero instances during the past 12 months where the facility determined that a resident was subject to substantial risk of imminent sexual abuse. Additionally, there have been no instances in which the agency had to isolate a resident due to imminent danger of sexual abuse that required immediate action. Policy 9.18*, Prison Rape Elimination Act (PREA),* states that, "When DYS learns that a resident is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the resident" *(p. 11).*

The interviewed agency head stated that our policy and expectation is that the direct care staff will immediately take steps to separate the alleged victim from the alleged perpetrator and notify the team leader, facility administrator, or assistant regional director. These staff will then determine the best options to protect the victim. The agency head and the manager indicated that such actions would occur

immediately. The interviewed manager also reported that they would keep eyes and ears on the situation through supervision and have it investigated.

All the interviewed staff could articulate the response process if a resident is at risk of imminent sexual abuse. report immediately, separate residents, close off the area of the incident, do not allow the resident to bath, shower, or brush teeth.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.363: Reporting to other confinement facilities

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.363 (a)

- Upon receiving an allegation that a resident was sexually abused while confined at another facility, does the head of the facility that received the allegation notify the head of the facility or appropriate office of the agency where the alleged abuse occurred? ☒ Yes ☐ No

- Does the head of the facility that received the allegation also notify the appropriate investigative agency? ☒ Yes ☐ No

115.363 (b)

- Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation? ☒ Yes ☐ No

115.363 (c)

- Does the agency document that it has provided such notification? ☒ Yes ☐ No

115.363 (d)

- Does the facility head or agency office that receives such notification ensure that the allegation is investigated in accordance with these standards? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy 9.18, *Prison Rape Elimination Act (PREA)*
    c. Policy 3.8 *Employee Conduct*
2. Interviews:
    a. Agency head
    b. Manager

115.363 (a). Policy 9.18, *Prison Rape Elimination Act (PREA)* states that, "If the allegations are involving sexual abuse that occurred while confined at another facility, the PREA compliance manager must notify the facility manager or appropriate reporting office where the alleged abuse occurred immediately, but no later than 72 hours from receipt of the allegation. Documentation of notification shall be maintained by the PREA Compliance manager" *(p. 11*). Policy 3.8, *Employee Conduct,* further elaborates that the head of the facility shall notify the appropriate investigative agency. Per the PAQ, there were no allegations of sexual abuse received at Ft. Bellefontaine which required notification to another facility head. Additionally, there were no reported allegations of sexual abuse received at another facility who which notification was received at Ft. Bellefontaine during the reporting period.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.363 (b). As previously reported, Policy 9.18, *Prison Rape Elimination Act (PREA)* states that, "If the allegations are involving sexual abuse that occurred while confined at another facility, the PREA compliance manager must notify the facility manager or appropriate reporting office where the alleged abuse occurred immediately, but no later than 72 hours from receipt of the allegation. Documentation of notification shall be maintained by the PREA Compliance manager" *(p. 11)*.

Per the PAQ, there were no allegations of sexual abuse received at Ft. Bellefontaine which required notification to another facility head. Additionally, there were no reported allegations of sexual abuse received at another facility who which notification was received at Ft. Bellefontaine during the reporting period. The manager reported if they received an allegation from another facility or agency that an incident of sexual abuse or sexual harassment occurred at Ft. Bellefontaine, they would request an investigation.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.363 (c). Per the PAQ, there were no allegations of sexual abuse received at Ft. Bellefontaine which required notification to another facility head. Additionally, there were no reported allegations of sexual

abuse received at another facility who which notification was received at Ft. Bellefontaine during the reporting period.

Based upon review of documentation the facility met the requirements of the provision.

115.363(d). As reported in the PAQ, the agency or facility requires that all allegations received from other agencies or facilities are investigated in accordance with the PREA standards. Policy 3.8, *Employee Conduct* states that:

> Employees are required to report suspicious or inappropriate conduct of other employees. Whenever a DYS employee has reasonable cause to suspect an abusive or neglectful incident has occurred, they should report immediately as outlined below. This includes, but is not limited to, any knowledge, suspicion or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in any residential/detention facility, even if external to DYS; any retaliation against resident or employee for having reported such an incident; and any employee neglect or violation of responsibilities that may have contributed to an incident or retaliation. All allegations of sexual abuse and harassment, including third-party and anonymous reports, must be investigated *(p. 6)*.

Based upon interviews with the manager, the facility hasn't had an incident where they received allegations from another facility, but if they did, they would document the allegation and report it through the hotline. There were no reported incidents of allegations within the last 12 months from other facilities.

The interviewed agency head reported that if another agency or a facility within your agency refers allegations of sexual abuse sexual harassment that occurred within one of your facilities, there is a designated point of contact. Policy mandates that upon receiving allegations that a resident was sexually abused while confined at another facility, the head of that facility must notify the head of the facility or appropriate office of the agency or facility where the sexual abuse is alleged to have occurred and that the head of the receiving facility notify the appropriate investigative agency. This notification should occur immediately but at a minimum within 72 hours.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.364: Staff first responder duties

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.364 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

115.364 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
   a. Pre-Audit Questionnaire (PAQ)
   b. DYS First Responder Protocols for Sexual Abuse
   c. DYS PREA Coordinated Response

2. Interviews:
    a. Random sample of staff/Security and non-security staff first responders - 12

Findings by Provision:

115.364 (a). The DYS First Responder Protocols for Sexual Abuse and the *PREA Coordinated Response*, provides the, First Responder Actions:

- Separate the victim and abuser
- Use crisis intervention techniques as necessary to ensure safety
- Separate witnesses
- Do not allow the victim or abuser to shower, wash, use the toilet, change clothes, eat or drink, brush his/her teeth, or rinse his or her mouth
- Attempt to preserve any bedding, clothing, towels or other items that could potentially be used as evidence.
- Contact law enforcement
- Contact Child Abuse and Neglect Hotline for youth under age 18
- Contact immediate supervisor. If the immediate supervisor is the abuser, notify the next level supervisor
- Provide emergency medical assistance, if necessary.
- Take victim to a local medical provider for examination.
- Observe the scene where the abuse was discovered, documenting the following:
    - ✓ Is anything out of place?
    - ✓ Are there any objects of note such as clothes?
    - ✓ Are there suspicious items on the floor?
    - ✓ Are there any obviously missing objects?
    - ✓ Are there puddles or stains?
    - ✓ What time is it?
    - ✓ Are the lights on
    - ✓ Who is present in the area?
- Assess and process the incident and situation
- Document the incident using the Critical Incident Reporting System

Per the PAQ, there were three allegations of sexual abuse reported in the last 12 months. The allegations were reported to investigations via the hotline and investigated immediately. It should be noted that all allegations are reported up through the hotline.

All of the staff at the facility are considered first responders. Twelve staff interviewed reported that the duties of a first responder are to take immediate action, move resident that was abused or harassed to a safe location, secure the scene, contact supervisor for additional directions.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.364 (b). All staff at the facility are considered first responders. Twelve staff interviewed reported that the duties of a first responder are to take immediate action, move resident that was abused or harassed to a safe location, secure the scene, contact supervisor for additional directions.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.365: Coordinated response

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.365 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. PREA DYS Coordinated Response
2. Interviews:
    a. Manager

Findings (By Provision):

115.365 (a). As reported in the PAQ, the facility developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse. The Ft. Bellefontaine facility has a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, immediate supervisor, PREA compliance manager/facility manager, medical, mental health, regional staff, and investigations.

When interviewing the manager, the process was further confirmed in that facility will follow the protocol identified in the responder protocol. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

Standard 115.366: Preservation of ability to protect residents from contact with abusers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.366 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? ☒ Yes ☐ No

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Labor Agreement Resolution
2. Interviews:
    a. Agency head

Findings (By Provision):

115.366 (a). As reported in the PAQ, the agency, facility, or any other government entity responsible for collective bargaining on the agency's behalf has entered into or renewed any collective bargaining agreement or other agreement since August 20, 2012, or since the last PREA audit, whichever is later.

There is a Labor Agreement between the State of Missouri Departments of Social Services and Health & Senior Services (Division of Senior and Disability Services and Division of Regulation and Licensure - Sections for Long Term Care and Child Care Regulation) and Office of administration (Division of Facilities Management design and Construction) and Communications Workers of America (CWA) Local 6355, AFL-CIO. The interviewed agency head further confirmed the above.

115.366 (b). The labor agreement does not exclude the authority to remove, transfer or termination of staff. It does establish representation for such action but does not exclude the facility's authority to suspend, transfer, or terminate staff with appropriate cause.

Corrective Action:

No corrective action is recommended for this standard.

Standard 115.367: Agency protection against retaliation

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.367 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? ☒ Yes ☐ No

- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

115.367 (b)

- Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with

victims, and emotional support services, for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations? ☒ Yes ☐ No

115.367 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: The conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: The conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Any resident disciplinary reports? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Resident housing changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Resident facility changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Negative performance reviews of staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Reassignments of staff? ☒ Yes ☐ No

- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

115.367 (d)

- In the case of residents, does such monitoring also include periodic status checks? ☒ Yes ☐ No

115.367 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation?
  ☒ Yes ☐ No

115.367 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
   a. Pre-Audit Questionnaire (PAQ)
   b. Policy 9.18, *Prison Rape Elimination Act (PREA)*
   c. DSS Policy 2-101, *Sexual Harassment/Inappropriate Conduct*
   d. Monitoring for retaliation 3
2. Interviews:
   a. Agency head
   b. Manager
   c. Designated staff member charged with monitoring retaliation - 1

Findings (By Provision):

115.367 (a). As reported in the PAQ, the facility has a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff. Policy 9.18, *Prison Rape Elimination Act (PREA*), states that:

a. In accordance with DSS Policy 2-109 Internal Investigations DYS provides protection to employees against retaliation for reports of sexual abuse or harassment or cooperation with investigations. Allegations of retaliation shall be immediately reported to the site supervisor or designee. In instances where the supervisor is believed to be involved in the retaliation, the employee shall notify the supervisor or designee at the next appropriate supervisory level. DYS Policy 6.1 Facility Programmatic Rights of Resident and Grievance Process provides protection of resident against retaliation. Prompt action shall be taken to remedy any such retaliation.
b. For 90 calendar days, or longer based on continuing need, following a report of sexual abuse, the PREA Compliance manager shall monitor the conduct or treatment of any individual, resident or

employee, who were involved in a reported incident, and shall act promptly to remedy any such retaliation. Monitoring steps include reviewing group, cottage or facility assignments, reviewing resident progress reports, periodic status checks with the resident, and performance reviews or reassignments of employees involved in the initial report or investigation.

c. DYS's obligation to monitor shall terminate if DYS determines that the allegation is unfounded *(pp. 10-11*).

Policy 2-101, *Sexual Harassment/Inappropriate Conduc*t further reiterates that, "Employees who report such conduct will not be subject to any form of retaliation. Managers and supervisors guilty of retaliatory treatment of any employee reporting such conduct will be subject to disciplinary action" *(p.* 1).

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.367 (b). As previously described, Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that, "For 90 calendar days, or longer based on continuing need, following a report of sexual abuse, the PREA Compliance manager shall monitor the conduct or treatment of any individual, youth or employee, who were involved in a reported incident, and shall act promptly to remedy any such retaliation. Monitoring steps include reviewing group, cottage or facility assignments, reviewing resident progress reports, periodic status checks with the resident, and performance reviews or reassignments of employees involved in the initial report or investigation *(pp. 11-12)*.

The facility reported in the PAQ, that zero residents that were placed on segregated housing after reporting sexual abuse or sexual harassment. The interviewed agency head reported that "we have policy in place that mandates retaliation monitoring. We allow required that he assistant regional supervisor monitor retaliation monitoring for resident and staff. We require weekly interviews with residents and monitor room changes, drop in grades, reduction in privileges, and interviews to determine for residents. The facility managers and assistant regional supervisor monitors staff retaliation. This includes changes of shifts, refusal for scheduled vacation time. Refusal to utilize staff for overtime or requiring staff to work overtime. We pay close attention to staff."

The interviewed manager reported that the following steps are taken to protect residents from staff retaliation: review shift logs, talk to the youth, read advocate notes, and follow up.

The interviewed staff that is designated to monitor for retaliation reported that they would be responsible for monitoring the resident. They would monitor by talking with the resident, observing the resident, reviewing shift logs, advocate notes, staffing during team and supervisor meetings. It was also reported that they would monitor for 90 days. There were three allegations of sexual abuse that was reported in the last 12 months. Upon review, the facility conducted the monitoring for retaliation immediately and up until the case was found unsubstantiated.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.367 (c). Policy 9.18, *Prison Rape Elimination Act (PREA),* states that, "For 90 calendar days, or longer based on continuing need, following a report of sexual abuse, the PREA Compliance manager shall monitor the conduct or treatment of any individual, resident or employee, who were involved in a reported incident, and shall act promptly to remedy any such retaliation" *(p. 10).* As reported in the PAQ, there were zero instances retaliation occurred. Upon review of three allegations of sexual abuse, the facility appropriately conducted monitoring for retaliation. It should be noted that one case involved a youth who was no longer at the program.

The manager is the designated staff who monitors for retaliation. They would monitor for 90 days after the incident or until the resident leaves the program. There were three allegations of sexual abuse that was reported in the last 12 months. Upon review, the facility conducted the monitoring for retaliation immediately and up until the case was found unsubstantiated or 90 days.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.367 (d). As previously stated, Policy 9.18, *Prison Rape Elimination Act (PREA),* monitoring will occur for 90 days or longer based on continuing need *(p. 11*). The PREA Coordinated Response Plan, describes the process in which staff will monitor for retaliation. There were three allegation of sexual abuse that was reported in the last 12 months. Upon review, the facility conducted the monitoring for retaliation immediately and up until the case was found unsubstantiated. It should be noted that one case involved a youth who was no longer at the program.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.367 (e). Missouri Division of Social Services (DSS) Policy 2-109, provides guidance on individual rights who cooperate with an investigation and express fear of retaliation.

The interviewed agency head reported that "staff or residents who report allegation of sexual abuse and residents that have made allegation of sexual abuse are monitored for a minimum of 90 days. Usually, the monitoring will continue until investigation is complete and residents and staff express no fear of retaliation. We monitor, the conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff; The conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff; any resident disciplinary reports; resident housing changes; resident program changes; negative performance reviews of staff and reassignments of staff. These are just a partial list of things we monitor. We also privately talk to the residents and staff on a regular basis."

As previously stated, the facility manager reported that they would monitor for retaliation, separate if needed, monitor supervision, take with the individuals, discuss during team meetings, and may adjust bed assignment. Monitoring would occur for 90 days. There were three allegations of sexual abuse that was reported in the last 12 months. Upon review, the facility conducted the monitoring for retaliation immediately and up until the case was found unsubstantiated. It should be noted that one case involved a youth who was no longer at the program.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.367 (f). The auditor is not required to audit this provision.

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.368: Post-allegation protective custody

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.368 (a)

- Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy 9.18, *Prison Rape Elimination Act (PREA)*
    c. Policy 9.8, *Separation*
    d. Investigation-3
2. Interviews:
    a. Manager
    b. Medical and mental health staff - 2

Findings (By Provision):

115.368 (a). PREA Policy 9.18, *Prison Rape Elimination Act (PREA),* "Resident at risk for sexual victimization, or those who have alleged to have suffered sexual abuse, will only be separated as a last resort and only until less restrictive measures can be found. When a resident is separated for these circumstances, minimal standards for conditions in accordance with PREA Standards115.342 and 115.378, and DYS Policy 9.8 Separation shall apply" *(p. 8)*.

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As reported in the PAQ, zero residents at risk for sexual abuse or sexual harassment who were held/placed in involuntary segregation. There were three allegations of sexual abuse/sexual harassment investigations to review. Upon review, it was found that the use of isolation or segregation was not

utilized. Interviews with the manager indicated that there were no residents who were placed on isolation to protect as a result of sexual abuse allegations. The manager also confirmed that they facility does not use isolation. However if for any reason isolation was used there would be a review every 30 days. The interviewed mental health and medical staff reported that isolation is not utilized at the facility. The interviewed staff reported that they are unaware of any residents being placed on isolation for sexual abuse or sexual harassment.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:
No corrective action is recommended for this standard.

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.371 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☐ Yes ☐ No ☒ NA

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).]
  ☐ Yes ☐ No ☒ NA

115.371 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334? ☒ Yes ☐ No

115.371 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses?
  ☒ Yes ☐ No

- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.371 (d)

- Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation? ☒ Yes ☐ No

115.371 (e)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? ☒ Yes ☐ No

115.371 (f)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff? ☒ Yes ☐ No

- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

115.371 (g)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No

- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

115.371 (h)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? ☒ Yes ☐ No

115.371 (i)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution? ☒ Yes ☐ No

115.371 (j)

- Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention? ☒ Yes ☐ No

115.371 (k)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation?
  ☒ Yes ☐ No

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

- When an outside agency investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
   a. Pre-Audit Questionnaire (PAQ)
   b. Policy 9.18, *Prison Rape Elimination Act (PREA)*
   c. Investigations-3
2. Interviews:
   a. Manager
   b. PREA coordinator
   c. PREA compliance manager
   d. Investigator -1

Findings (By Provision):

115.371 (a). As reported in the PAQ, the facility has a policy related to the investigation protocols. Policy 9.18, *Prison Rape Elimination Act (PREA),* states that, "Criminal and administrative agency investigations:

a. The DYS shall refer all allegations of sexual abuse and sexual harassment to the appropriate investigative agencies based upon the victim's age as defined in DYS Policy 3.8 Employee Conduct. DYS has conveyed the PREA requirements to appropriate external investigating agencies.
b. When outside agencies investigate sexual abuse and sexual harassment, DYS shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation."

The agency does not conduct its own investigations; however, the DSS interviewed investigator reported that once the Division of Legal Services is notified by the Division of Youth Services that an allegation of sexual abuse has been made, an investigation is immediately initiated. The interviewed investigator also reported that if an anonymous or third party reports sexual abuse or sexual harassment, such reports are treated the same as other referrals and are not handled any differently. DLS will still accept the report.

There were three allegations of sexual abuse that occurred during the last 12 months. The allegation was immediately reported to the outside investigator. The investigative report consisted of the allegations, statements, and an investigation summary.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.371 (b). Per the PAQ, the Ft. Bellefontaine Campus facility reported having zero staff who are trained investigators. The interviewed DSS investigator reported that he received training specific to sexual abuse and sexual harassment investigations in confinement settings. It was also reported that all of the DSS agents that conduct sexual abuse investigations have attended the Specialized Training in Investigating Sexual Abuse in Correctional settings from the National PREA Resource Center.

The agency does not conduct any form of administrative or criminal sexual abuse investigations. However, the auditor spoke with one of the investigators for DSS. The interviewed investigator reported that the training topics included:

- Techniques for interviewing juvenile sexual abuse victims.
- Proper use of Miranda Garrity warnings.
- Sexual abuse evidence collection in confinement settings.
- The criteria and evidence required to substantiate a case administrative or prosecution referral.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.371 (c). The facility does not administrative PREA related investigations, and all criminal investigations are handled by an outside entity. The agency does not conduct any administrative or criminal investigations. One of the entities that conducts the PREA related allegations is the umbrella agency DSS. The DSS interviewed investigator reported that, "the first step of our investigation would be the 'information gathering stage' to gather information regarding the specific allegations of sexual abuse. This information gathering may look different in each case, but generally, the first steps would be to

review statements made the victim/witness and then interview the victim/witnesses to get their side of the story and to identify other potential witnesses or evidence in the case. DLS would also ensure the information was provided to the child abuse and neglect hotline when applicable if the victim was a juvenile."

As reported in the PAQ the facility does not terminate an investigation solely because the source of the allegation recants the allegation. The interviewed DLS investigator reported that they will not terminate an investigation if the source of the allegation recants his/her allegation. If a source recants allegations, the investigation still continues. DLS Investigators are aware that many sources of information (victims or witnesses) often recant statements for a multitude of reasons.

There were three allegations of sexual abuse that occurred in the last 12 months. The allegation was immediately reported to the outside investigator. The investigative report consisted of the allegations, statements, and an investigation summary.

It was also reported that the investigation process for sexual abuse allegations is done objectively, thoroughly and impartially by a trained investigator. The process includes gathering evidence (physical and documentary), conducting interviews with the alleged victim (s)/witness(es)/suspect (s) and documenting findings in an investigative report. When conducting an investigation direct and circumstantial evidence will be gathered on a case-by-case basis; as the evidence is different in every case. In general, direct/circumstantial evidence would include the possibility of DNA (if timely reported), video footage from the facility, phone logs, text messages, handwritten letters, computer/email audit results, statements from the victim(s)/suspect(s)/witness(es).

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.371 (d). While the agency does not conduct administrative and criminal investigations, it was reported that the investigation would not terminate because the source of the allegation recants the allegation.

115.371 (e). The agency does not conduct administrative and criminal investigations. However, the interviewed DLS investigator reported that "DLS does consult with prosecutors if/when needed, however, we don't necessarily consult with them on every case." Investigators in Division of Legal Services are well aware that a compelled statement from an employee suspect will not be admissible as evidence in a criminal trial. DLS does not offer the Garrity warning in criminal cases. If DLS does decides to take a compelled statement and then criminal activity is learned of through the compelled statement, any potential criminal acts will be referred to law enforcement for investigation. It is important to note that information and evidence from law enforcement can and will be included in an administrative investigation, but information/evidence gathered during compelled administrative investigations should not be shared with law enforcement, so it does not taint their case.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.371 (f). The interviewed DLS investigator reported that the credibility of an alleged victim, suspect or witnessed are individually based upon other learned facts, details and supporting/conflicting evidence gathered during the investigations. Race, color, creed, national origin, gender, age, disability, military status, and other protected class category is not considered when judging the creditability of an alleged victim, neither is the fact that an alleged victim may be a resident in a correctional facility is not considered

either. It was also reported that under no circumstance would they require a resident who alleges sexual abuse to submit to a polygraph examination or truth telling device as a condition for proceeding with an investigation.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.371 (g). The interviewed DLS investigator reported that "DLS investigations not only looks at the individual actions of the suspects, but we take a holistic view and approach to each investigation to make informed decision as to whether or not the incident was limited to staff action(s) or if failures to act facilitated the abuse." Administrative investigations are documented in a thorough, written investigative report. The report contains: the who, what, when, where, why and how if known, along with copies of all supporting documentary evidence gathered during the investigations that are laid out as exhibits within the report. The report will document a finding if the case is substantiated, unfounded or not substantiated. If substantiated, the report will document what and how each DSS or Division policy(ies) were violated.

There were three allegations of sexual abuse that occurred during the last 12 months. The allegation was immediately reported to the outside investigator. The investigative report consisted of the allegations, statements, and an investigation summary. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.371 (h). The facility does not conduct administrative or criminal investigations; however, the outcomes of such investigations are provided by entity responsible for the investigations. The Missouri Children's Division Out of Home Investigation Unit investigates sexual abuse/harassment for DYS regarding youth under the age of 18. Children over the age of 17 are referred to Division of Legal Services Investigation Unit. In cases that are criminal in nature the facility administrator would contact the local law enforcement. In other cases, the Division of Legal Services Investigation Unit would conduct the investigation or notify the local law enforcement and investigate along with the local law enforcement. Missouri Division of Youth Services has requested the agencies that conduct allegation of sexual abuse or sexual harassment follow the PREA standards.

The interviewed DLS investigator reported that criminal investigations are documented in a thorough, written investigative report. The report contains the who, what, when, where, why and how if known, along with copies of all supporting documentary evidence gathered during the investigations that are laid out as exhibits within the report. The report will document what laws were violated, in which county and on what dates. There were three allegations of sexual abuse that occurred during the last 12 months. The allegations were immediately reported to the outside investigator. The investigative report consisted of the allegations, statements, and an investigation summary.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.371 (i). As reported in the PAQ, there were zero substantiated allegations of conduct that appear to be criminal that were referred for prosecution since August 20,2012, or since the last PREA audit. As previously stated, the Missouri Children's Division Out of Home Investigation Unit investigates sexual abuse/harassment for DYS regarding youth under the age of 18. Children over the age of 17 are referred to Division of Legal Services Investigation Unit. In cases that are criminal in nature the facility administrator would contact the local law enforcement. In other cases, the Division of Legal Services Investigation Unit would conduct the investigation or notify the local law enforcement and investigate

along with the local law enforcement. Missouri Division of Youth Services has requested the agencies that conduct allegation of sexual abuse or sexual harassment follow the PREA standards.

The interviewed DLS investigator stated that DLS would refer a case for prosecution if/when there is probable cause to believe a criminal act has occurred. There were three allegations of sexual abuse that occurred during the last 12 months. The allegations were immediately reported to the outside investigator. The investigative report consisted of the allegations, statements, and an investigation summary. The allegation was found unsubstantiated and did not require further actions.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.371 (j). As reported in the PAQ the agency retains all written reports pertaining to administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

115.371 (k). The interviewed DLS investigator reported that, "If a staff member terminates their employment before an investigation is complete, the investigation will still continue until completion. DLS does not stop investigating allegations of sexual abuse simply because an employee resigned or was terminated from employment." It was also reported that if a victim alleging sexual abuse or sexual harassment leaves the facility prior to the completion of the investigation it will be handled similar to above, the investigation would continue. Simply because a victim leaves a facility prior to the completion of an investigation is not reason to stop the investigation. DLS still has a duty to all involved to complete a thorough and complete investigation. There was one allegation that was reported after the resident left the facility. The allegation was referred to investigations.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.371 (l). N/A

115.371 (m). The interviewed manager/PCM, reported that, final findings are always sent back to the facility via email, phone calls in writing or in person.

The interviewed PREA coordinator reported that the agency will always cooperate with outside agencies when investigating an allegation. The PREA coordinator advised that, they will be "notified by agency of initial hotline received, PREA Compliance manager communicates progress, agency sends completed investigation directly to the Statewide PREA Coordinator." The interviewed DLS investigator reported that "if an outside agency investigates allegation of sexual abuse in a facility, our role would be supportive and cooperate with the agency conducting the investigation and provide them timely access to the facility, any witnesses, victims or information/evidence asked for."

There were three allegations of sexual abuse that occurred during the last 12 months. The allegation was immediately reported to the outside investigator. The investigative report consisted of the allegations, statements, and an investigation summary. Upon review, it was found that there was ongoing communication between the agency and the investigator.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.372: Evidentiary standard for administrative investigations

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.372 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. External Investigations-Child welfare manual
    c. Investigation-3
2. Interviews:
    a. Investigator - 1

Findings (By Provision):
115.372 (a). The facility reported in the PAQ, that the agency does not conduct administrative or criminal investigations.

The interviewed DLS investigator reported that the standard of evidence used to substantiate an allegation of sexual abuse or sexual harassment would be a preponderance of evidence. There were three allegation of sexual abuse that occurred during the last 12 months. The allegations were immediately reported to the outside investigator. The investigative report consisted of the allegations, statements, and an investigation summary.

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.373: Reporting to residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.373 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? ☒ Yes ☐ No

115.373 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in the agency's facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☐ Yes ☐ No ☒ NA

115.373 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.373 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the

alleged abuser has been indicted on a charge related to sexual abuse within the facility?
☒ Yes ☐ No

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?
☒ Yes ☐ No

115.373 (e)

- Does the agency document all such notifications or attempted notifications? ☒ Yes ☐ No

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy 9.18, *Prison Rape Elimination Act (PREA)*
    c. Notification-1
2. Interviews:
    a. Manager
    b. Investigator – 1

Findings (By Provision):
115.373 (a). 115.373 (a). As reported in the PAQ, the facility has a policy requiring that any resident who makes an allegation that he or she suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency. Policy 9.18, *Prison Rape Elimination Act (PREA*), states that, "Following an investigation into a resident's allegation of sexual abuse suffered in a residential

facility, the PREA Compliance manager shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded" *(p. 12)*. The PAQ indicated that there were three criminal or administrative PREA related incidents in the last 12 months. The allegations were investigated, and victim notification occurred.

The interviewed manager reported that the facility will notify residents of allegations of sexual abuse. There were three allegations of sexual abuse or sexual harassment; and notification was properly conducted and documented. The interviewed DLS investigator reported that DLS only provides investigative findings to the Human Resource director of DSS and the Human Resource manager for each Division. In cases involving a resident at a juvenile facility, DYS HR should provide the investigative findings to leadership personnel at the facility to inform the resident of the findings.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.373 (b). The Ft. Bellefontaine facility utilizes an outside entity to conduct the criminal investigations. As reported in the PAQ, there were zero investigations of alleged resident sexual abuse in the facility. Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that, "Following a resident's allegation that an employee member has committed sexual abuse against the resident, the PREA Compliance manager shall subsequently inform the resident (unless DYS has determined that the allegation is unfounded) whenever:

1. The employee is no longer assigned to the resident's treatment team;
2. The employee is no longer employed at the facility;
3. DYS learns that the employee has been charged with a law violation related to a sexual abuse incident within the facility; or
4. DYS learns that the employee has been convicted of a law violation related to a sexual abuse incident within the facility.

There were three allegations of sexual abuse made in the last 12 months. The allegations were immediately reported to the outside investigator. Upon the conclusion of the investigation, the investigative entity provided the MO DSS Investigation/Assessment Summary.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.373 (c). The facility reported in the PAQ that following a resident's allegation that a staff member has committed sexual abuse against a resident, the facility will provide information on the staff member's presence/employment at the facility. In specific, Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that, "When outside agencies investigate sexual abuse and sexual harassment, DYS shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation" *(p. 12)*. There were three allegations of sexual abuse made in the last 12 months. The allegation was investigated, and victim notification occurred.

115.373 (d). The facility reported in the PAQ that it would notify a resident on the results of an allegation that he/she was sexually abuse by another resident the results of the investigation. More specifically, the Policy *9.18, Prison Rape Elimination Act (PREA)*, states that:
Following a resident's allegation that he or she has been sexually abused by another resident, the PREA Compliance manager shall subsequently inform the alleged victim whenever:

1. DYS learns that a petition has been filed against the alleged abuser or the alleged abuser has been charged with a law violation related to a sexual abuse incident within the facility; or

2. DYS learns that the alleged abuser has been adjudicated or convicted on a charge related to sexual abuse within the facility *(p.13).*

There was no identified resident on resident sexual abuse allegations. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.373 (e). As reported in the PAQ, the Ft. Bellefontaine facility has a policy that all notifications to residents described under this standard are documented. *Policy 9.18, Prison Rape Elimination Act (PREA),* states that, "The PREA Compliance manager will ensure all notifications or attempted notifications shall be documented and maintained for auditing purposes" *(p. 13)*.

There were three reported allegations of sexual abuse or sexual harassment. Upon the conclusion of the investigation, the facility provided notification to the resident. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.373 (f). The auditor is not required to audit this provision.

Corrective Action:
No corrective action is recommended for this standard.

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.376 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No

115.376 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☒ Yes ☐ No

115.376 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? ☒ Yes ☐ No

115.376 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the

facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy 9.18, *Prison Rape Elimination Act (PREA)*
    c. Policy 2-124, *Discipline*
    d. Investigation-3
2. Interviews:
    a. Manager

Findings (By Provision):

115.376 (a). The Ft. Bellefontaine facility reported in the PAQ that staff are subject to disciplinary sanctions up to and including termination for violating agency sexual abuse and sexual harassment policies. Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that, "DYS employees shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies as defined in this policy, DSS Policy 2-124 Discipline, DSS Policy 2-101 Sexual Harassment/ Inappropriate Conduct and DYS Policy 3.8 Employee Conduct" *(p.13)*.

There were three reported allegation of sexual abuse or sexual harassment. The allegation was found unsubstantiated or unfounded. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.376 (b). The Ft. Bellefontaine facility reported in the PAQ that there was one staff that violated the agency's sexual abuse or sexual harassment policies. However, in the event there was an instance of staff violating the sexual abuse and sexual harassment policy, DSS Policy 2-124, *Discipline*. indicates that staff are subject to disciplinary sanctions up to and including termination.

115.376 (c). DSS Policy 2-124, *Discipline*, provides guidance that the "type of corrective measures or disciplinary action applied to address a problem will be based on the severity of the offense, the previous work record of the employee or other relevant factors" *(p.2)*. According to the PAQ, there were no disciplinary sanctions imposed during the 12-month reporting period that would apply to this standard provision; however according to section c there was one staff terminated.

115.376 (d). All employees who are terminated and/or resign in lieu of termination due to violations of the sexual abuse and sexual harassment policy shall be reported to law enforcement. According to the PAQ, there have been zero staff from the facility that have been reported to law enforcement or licensing boards following their termination for violating agency sexual abuse or sexual harassment policies.

Corrective Action:

No corrective action is recommended for this standard.

Standard 115.377: Corrective action for contractors and volunteers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.377 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

115.377 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy 9.18, Prison Rape Elimination Act (PREA)
2. Interviews:
    a. Manager

Findings (By Provision):

115.377 (a). Policy 9.18, *Prison Rape Elimination Act (PREA),* states that, "Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with resident and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies" *(p. 14).*

As reported in the PAQ, there have been zero volunteers or contractors who have been reported to law enforcement agencies and relevant licensing bodies for engaging in sexual abuse of residents in the past 12 months; nor any incidents/persons reported to law enforcement for engaging in sexual abuse of residents. Based on review of files it is found that the facility meets the requirements of the standard.

115.377 (b). There have been zero instances in the past 12 months where the Ft. Bellefontaine Campus facility had to take action on a volunteer or contractor. The facility has a policy in place to address any volunteers or contractors who violate the PREA standards of sexual abuse and sexual harassment. During the interview with the manager, it was reported that the facility would have the incident investigated and the volunteer or contractor services would be terminated.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.378: Interventions and disciplinary sanctions for residents

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.378 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process? ☒ Yes ☐ No

115.378 (b)

- Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational facility programming or special education services? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other facilities and work opportunities to the extent possible? ☒ Yes ☐ No

115.378 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? ☒ Yes ☐ No

115.378 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions? ☒ Yes ☐ No

- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general facility programming or education? ☒ Yes ☐ No

115.378 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

115.378 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No

115.378 (g)

- If the agency prohibits all sexual activity between residents, does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the

facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy 9.18, *Prison Rape Elimination Act (PREA)*
2. Interviews:
    a. Manager
    b. Medical and mental health staff - 2

Findings (By Provision):

115.378 (a). Policy 9.18, *Prison Rape Elimination Act (PREA*), states that, "Youth found to have sexually harmed others shall be offered therapy counseling or other interventions designed to address and correct the underlining reasons for their conduct" *(p. 14).* As reported in the PAQ, there were no reported residents subject to disciplinary sanctions following an administrative finding that the resident engaged in resident-on-resident sexual abuse, following a criminal finding of guilt for resident-on-resident sexual abuse.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.378 (b). As previously stated, Policy 9.18, *Prison Rape Elimination Act (PREA*), states that, "Youth found to have sexually harmed others shall be offered therapy counseling or other interventions designed to address and correct the underlining reasons for their conduct" *(p. 14*). Per the PAQ, there were zero residents in the past 12 months placed in isolation as a disciplinary sanction for resident-on-resident sexual abuse.

The interviewed manager reported that they do not use sanctions against the residents. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.378 (c). As previously stated, Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that, "Youth found to have sexually harmed others shall be offered therapy counseling or other interventions designed to address and correct the underlining reasons for their conduct" *(p. 14)*. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.378 (d). Per the PAQ, the Ft. Bellefontaine Campus facility offers therapy, counseling and other interventions designed to address and correct underlying reasons or motivations for the abuse. However the facility does not offer therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for the abuse, the facility does not consider whether to require the offending resident to participate in such interventions as a condition of access to any rewards -based behavior management system or other behavior-based incentives.

Interviews with the medical and mental health staff, indicated that all residents are offered individual and group related services; and perpetrating services would be offered. The interviewed mental health staff reported that services are not tied to a reward-based system; however, the medical staff reported that it

is tied to a rewards-based program. The auditor recommended refresher training to ensure staff are aware of the process for medical and sexual abuse allegations. The refresher training occurred on 5/1/2021.

115.378 (e). As reported in the PAQ, the Ft. Bellefontaine facility disciplines resident for sexual contact with staff only upon finding that the staff member did not, consent to such contact. As previously stated, Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that, "Youth found to have sexually harmed others shall be offered therapy counseling or other interventions designed to address and correct the underlining reasons for their conduct" *(p. 14)*. There were zero reported allegations of sexual abuse or sexual harassment in which a resident displayed inappropriate sexual contact with a staff member.

115.378 (f). As reported in the PAQ, the facility prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.

115.378 (g). As reported in the PAQ, that facility prohibits sexual activity between residents. Upon review of the resident PREA education material (Safety 1st), it indicates that "true consent means both partners have equal power. Equal power means equal knowledge and equal freedom to make decisions, without pressure."

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

The auditor recommended refresher training to ensure staff are aware of the process for medical and sexual abuse allegations. The refresher training occurred on 5/1/2021. There are no further corrective actions recommended for the standard.

MEDICAL AND MENTAL CARE

Standard 115.381: Medical and mental health screenings; history of sexual abuse

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.381 (a)

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (b)

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (c)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and facility assignments, or as otherwise required by Federal, State, or local law? ☒ Yes ☐ No

115.381 (d)

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy 9.18, *Prison Rape Elimination Act (PREA)*
    c. Policy 7.2, *Standards PREA Vulnerability Information Review (PVIR)-23*
    d. Facility Health Screening-23
    e. Telehealth Note-3
    f. 18 Over Consent Form-Blank
    g. Refresher PVIR Training (dated 5/3/2021)
    h. Updated PVIRs-2
2. Interviews:
    a. Staff responsible for Risk Screening - 1
    b. Medical and mental health staff – 2

Findings (By Provision):

115.381 (a). As reported in the PAQ, residents at the facility who disclosed any prior sexual victimization during a screening pursuant to 115.341 are offered a follow-up meeting with a medical or mental health practitioner. The Ft. Bellefontaine Campus reported in the PAQ, that 100% of the residents who reported prior victimization during screening were offered a follow-up meeting with a medical or mental health practitioner. Policy 9.18, *Prison Rape Elimination Act (PREA)* states that, "If the screening completed in accordance with DYS Policy 9.5 Residential Care indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, DYS employees shall ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening in accordance with DYS Policy 7.2 Standards" *(p. 14).*

The interviewed staff responsible for risk screening stated that if a screening indicates that a resident has experienced prior sexual victimization whether in an institutional setting or in the community; follow up medical or mental health services would be offered within 14 days.

The auditor reviewed the assessments (PVIR) for 23 residents who were placed at the facility in the last 12 months. Upon review, it was determined that while the facility was completed the PVIRs they were not completing them according to instruction. It was recommended by the auditor that the facility manager is retrained on completing the assessments.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.381 (b). As stated previously, residents that have previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, will be offered a follow up meeting with a mental health practitioner. Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that, "If the screening completed in accordance with DYS Policy 9.5 Residential Care indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, DYS employees shall ensure that the resident is offered a follow-up meeting with a mental health practitioner

within 14 days of the intake screening in accordance with DYS Policy 7.2 Standards" *(pp.14-15)*. It was also reported that the intake process includes an automatic meeting with the medical and mental health staff.

As indicated in the PAQ, one hundred percent of residents who disclosed prior perpetration of sexual abuse during screening are offered a follow up meeting with a mental health practitioner. However, upon review of 23 *PVIR's*, there was six residents who reported a prior history of sexual perpetration. The interviewed staff responsible for performing screening for risk of victimization and abusiveness reported that all residents have a follow up within 30 days.

115.381 (c). Policy 9.18, *Prison Rape Elimination Act (PREA)* states that, "Any information related to sexual victimization or abusiveness that occurred in a residential setting shall be strictly limited to medical and mental health practitioners and other employees, as necessary, to inform treatment plans and safety decisions, or as otherwise required by Federal, State, or local law in accordance with DYS Policy 4.1 Dissemination of Information and DYS Policy 6.1 Facility Programmatic Rights of Resident and the Grievance Process" *(p. 15)*.

115.381 (d). As reported in the PAQ, medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18. Policy 9.18, *Prison Rape Elimination Act (PREA)* states that, "Medical and mental health practitioners shall obtain informed consent from resident before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18" *(p. 15*).

The interviewed medical and mental health staff stated that because the residents are minors, they would have to make a report regardless of consent. However, if the resident is over 18 they would obtain informed consent. It was also reported that the residents are informed of the limitations of confidentiality. There were no residents 18 and over. The review of documentation provided evidence of staff compliance with the standard.

Corrective Action:
Upon review of the PVIRs it was identified that the PVIRs were not being completed according to instruction. The auditor recommended that the facility manager complete a refresher training on how to complete the PVIRs. The refresher training was conducted on 5/3/2021. Additionally, the facility shall provide completed PVIRs, showing proof of corrected completion. Two PVIRs were provided, demonstrating the ability to complete the forms in the correct manner. No further action required.

Standard 115.382: Access to emergency medical and mental health services

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.382 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment? ☒ Yes ☐ No

115.382 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362? ☒ Yes ☐ No

- Do staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.382 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☒ Yes ☐ No

115.382 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy 9.18, Prison Rape Elimination Act (PREA)
    c. Investigations-3
2. Interviews:
    a. Medical and mental health staff - 2
    b. Security staff and non-security staff first responders-12
    c. Medical and mental health staff first responders

Findings (By Provision):

115.382 (a). As reported in the PAQ, resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. It further stated that the nature and scope of such services are determined by medical and mental health practitioners according to their professional judgement.

The interviewed mental health and medical staff reported that victims of sexual abuse receive timely and unimpeded access to emergency medical treatment and crisis intervention services. Such services are rendered immediately upon notification. Medical and mental health staff interviewed during the site review were able to clearly state their responsibilities in responding to a reported incident of sexual abuse.

There were three allegations of sexual abuse reported. One of the allegations of sexual abuse was reported and investigated after the resident left the program. The other two allegations of sexual abuse were followed up with mental health services and documented on a telehealth note.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted

115.382 (b). Twelve of the direct care staff interviewed, as staff who act as first responders, reported that the duties of a first responder include, but are not limited to: take immediate action, stay with the resident, separate the victim from the perpetrator, isolate/secure the scene and secure evidence, call for additional staff, and notify supervisor. It should be noted that all of the direct care staff who work in the facility are considered and trained as first responders.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.382 (c). As reported in the PAQ, resident victims of sexual abuse while incarcerated are offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Interviewed medical and mental health staff reported that such services are addressed immediately.

There were three PREA related allegations reported during the 12-month audit period. None of the allegations required follow up medical services; however the residents at the facility were offered services. The interviewed medical and mental health staff reported that any needed current or follow up services would be coordinated with the on-site medical staff.

115.382 (d). As reported in the PAQ, the treatment services provided to every victim is without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out the incident. Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that:

- Treatment services will be provided to all victims of abuse as outlined in DYS Policy 7.4 Access to Health Care Services, regardless of the victim's willingness to name the abuser or cooperate in any subsequent investigation.
- Forensic medical exams and treatment services will be offered without financial cost to the victim. Services will be provided whether the victim names the abuser or cooperates with any investigation arising out of the incident *(p. 15-16).*

There were three PREA related allegations reported in the last 12 months. The allegation was reported immediately and follow up services were offered. None of the allegations required follow up medical services.

Corrective Action:
No corrective action is recommended for this standard

Standard 115.383: Ongoing medical and mental health care for sexual abuse victims and abusers

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.383 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

115.383 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☒ Yes ☐ No

115.383 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

115.383 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☐ Yes ☐ No ☒ NA

115.383 (e)

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☐ Yes ☐ No ☒ NA

115.383 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

115.383 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

115.383 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy 9.18, *Prison Rape Elimination Act (PREA)*
    c. Policy 6.1, Facility Programmatic Rights of Resident and the Grievance Processes
    d. Policy 7.2, *Standards*
    e. Policy 7.3, *Special Needs*
    f. Policy 7.4, *Access to Medical*
    g. Refresher Training-1
    h. Investigation-3
2. Interviews:
    a. Medical and mental health staff – 2

Findings (By Provision):

115.383 (a). As reported in the PAQ, the facility offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail,

lockup, or juvenile facility. Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that, "The facility shall offer medical and mental health evaluations and appropriate treatment in adherence to PREA Standards 115.383 in accordance with DYS Polices 6.1 Facility Programmatic Rights of Resident and the Grievance Process, 7.2 Standards, 7.3 Special Needs and 7.4 Access to Health Care Services" *(p. 16)*.

The following Policies further provide services to victims:

- Policy 6.1*, Facility Programmatic Rights of Resident and the Grievance Process*-" Appropriate medical and dental treatment in accordance with DYS Policy Chapter 7 Medical and Health Care" *(p. 2)*.
- Policy 7.2, *Standards*- "The Regional Nurse shall establish procedures which ensure residents whose initial placement is residential or day treatment, receive a *Nurse Assessment* (DYS: F4-16) as soon as possible, but not to exceed 10 working days. Any urgent concerns previously communicated by the *Facility Health Screen* (DYS: F7-17) or *Initial Health Screening* (DYS: F4-3) shall be addressed upon placement in any DYS facility. For resident without a current physical examination record, a physician's *Physical Examination Report* (DYS: F7-17) or Healthy Children and Resident Screening Guide (HCY) shall occur within 15 working days of placement to any DYS residential facility or as soon as possible based on MC+ activation" *(p. 3)*.
- Policy 7.3, *Special Needs*- "Resident who have been assessed to have special health care needs but who are not placed in a DYS residential facility shall have those needs identified within the Comprehensive Individual Treatment Plan (CITP). The SC in conjunction with the Regional Nurse or designee shall specify the identified need, the current treatment being administered, support the family and ensure that the resident obtains necessary health care services from community resources" *(pp. 1-2*).
- Policy 7.4, *Access to Medical*- "All residents under the direct care, custody and control of the Division of Youth Services (DYS) shall have unimpeded access to appropriate health care services to ensure that health care needs, including prevention and health education, are met in a timely and efficient manner" *(p. 1)*.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

185.383 (b). The interviewed medical and mental health staff stated that immediate care would be rendered. The residents usually would be evaluated and treated at a mental health facility or hospital. The hospital makes recommendations upon their release regarding any follow-up services and additional treatment needed. They receive follow-up and counseling services from DYS once they return from the hospital and when they're release from a DYS facility to aftercare. Follow up care may include counselling, treatment plan, referrals for continued care, offered pregnancy tests, STD testing, without

115.383 (c). As reported by the interviewed medical and mental health staff, the treatment and services provided are consistent with the community level of care.

115.383 (d). N/A the facility only provides services to male residents.

115.383 (e). N/A the facility only provides services to male residents.

115.383 (f). As reported in the PAQ, resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate. Ft. Bellefontaine staff will ensure that

residents of sexual abuse are provided a sexually transmitted infections test, along with receiving any necessary follow up medical care. Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that "The facility shall offer medical and mental health evaluations and appropriate treatment in adherence to PREA Standards 115.383 in accordance with DYS Polices 6.1 Facility Programmatic Rights of Resident and the Grievance Process, 7.2 Standards, 7.3 Special Needs and 7.4 Access to Health Care Services" *(p. 16)*.

There were zero identified current residents who reported sexual abuse at the Ft. Bellefontaine facility.

115.383 (g). Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that:

- Treatment services will be provided to all victims of abuse as outlined in DYS Policy 7.4 Access to Health Care Services, regardless of the victim's willingness to name the abuser or cooperate in any subsequent investigation.
- Forensic medical exams and treatment services will be offered without financial cost to the victim. Services will be provided whether the victim names the abuser or cooperates with any investigation arising out of the incident *(p. 15-16).*

There were zero identified current residents who reported sexual abuse at the Ft. Bellefontaine facility.

115.383 (h). As reported in the PAQ, the Ft. Bellefontaine facility, attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate by mental health practitioners. Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that:

Ongoing medical and mental health care for sexual abuse victims and abusers:

- The facility shall offer medical and mental health evaluations and appropriate treatment in adherence to PREA Standards 115.383 in accordance with DYS Polices 6.1 Facility Programmatic Rights of Resident and the Grievance Process, 7.2 Standards, 7.3 Special Needs and 7.4 Access to Health Care Services *(p. 16).*

The interviewed mental health staff reported that they assess for risk and if needed, the resident will be sent to a mental health facility for a mental health evaluation. It should also be noted that the mental health staff reported N/A for conducting any evaluation once they learn a resident has a history of sexual abuse. The auditor recommended refresher training to refresh medical staff on the responsibilities related to sexual abuse allegations. The refresher training occurred on 5/1/2021.

Corrective Action:

The auditor recommended refresher training to refresh medical staff on the responsibilities related to sexual abuse allegations. The refresher training occurred on 5/1/2021. There are no further actions recommended for the standard.

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.386 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☒ Yes ☐ No

115.386 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

115.386 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

115.386 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.386 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy 9.18, *Prison Rape Elimination Act (PREA)*
    c. Policy 9.17, *Critical Incidents*
    *d. Critical Incident Review For*m-3
2. Interviews:
    a. Manager
    b. PREA compliance manager
    c. Incident review team - 2

Findings (By Provision):

115.386 (a). As reported in the PAQ, the Ft. Bellefontaine Campus facility, conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded. Policy 9.18, *Prison Rape Elimination Act (PREA)* states that, "At the conclusion of a sexual abuse investigation, the PREA Compliance manager shall ensure a review is conducted using *Critical Incident Review Form* F9-71, including when the allegation has not been substantiated, unless the allegation has been determined to be unfounded. Such review shall ordinarily occur within 30 days of the conclusion of the investigation. The review team shall include supervising Deputy Director, Regional Administrator (RA), Assistant Regional Administrator (ARA), Facility Manager(s) and Resident Group Leader(s), with input from investigators, and medical or mental health providers" *(p. 16).*

Policy 9.17, *Critical Incidents*, further states that, "A Critical Incident Review shall occur immediately, but not more than 30 days from the conclusion of the investigation for sexual assaults, sexual misconduct, successful runaways, and behavior injurious to self/others requiring outside medical attention. (For those incidents involving sexual abuse, a review shall be conducted even if the allegation was not

substantiated. A review is not necessary when the sexual abuse allegation has been determined to be unfounded)" *(p. 4)*.

There was three allegations of sexual abuse reported during the last 12 months. Upon the conclusion of the investigation, the facility conducted the incident review utilizing the Critical Incident Review Form. The review occurred within 30 days of the conclusion of the investigation.

115.386 (b). Policy 9.17, *Critical Incidents*, further states that, "A Critical Incident Review shall occur immediately, but not more than 30 days from the conclusion of the investigation for sexual assaults, sexual misconduct, successful runaways, and behavior injurious to self/others requiring outside medical attention. (For those incidents involving sexual abuse, a review shall be conducted even if the allegation was not substantiated. A review is not necessary when the sexual abuse allegation has been determined to be unfounded)" *(p.* 4).

There were three allegations of sexual abuse reported during the last 12 months. Upon the conclusion of the investigation, the facility conducted the incident review utilizing the Critical Incident Review Form. The review occurred within 30 days of the conclusion of the investigation.

115.386 (c). Policy 9.17, *Critical Incidents* states that, "The review team shall include appropriate management staff. For incidents involving sexual assaults or misconduct the review team will include the supervising Deputy Director, RA, ARA, Facility Manager(s) and Resident Group Leader(s), with input from investigators, and medical or mental health providers" *(p. 4)*.

As reported in the PAQ, the sexual abuse incident review team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners. The interviewed manager reported that the sexual abuse incident review team consists of upper-level management, medical and mental health practitioners. There were three allegations of sexual abuse reported during the last 12 months. Upon the conclusion of the investigation, the facility conducted the incident review utilizing the Critical Incident Review Form. The review occurred within 30 days of the conclusion of the investigation.

115.386 (d). The agency utilizes a critical incident review form to document findings from sexual abuse incidents. The form addresses the following:

- Description of the incident
- Identify contributing factors
    - Underlying issues
    - Needs
    - Casual Factors to include physical environment or barriers and technology
    - Youth employee team dynamics and needs
    - Programming system issues
    - Employee supervision/coverage mandates
- Other considerations
    - Assess whether the incident of allegation was motivated by race; ethnicity, gender identity; lesbian, gay, bisexual, transgender, or intersex identification status or perceived status
    - Gang affiliation, or
    - Motivated or otherwise caused by other group dynamics at the facility
- Learning points
- Potential impact of the incident
- Actions to be taken

The manager/PCM reported that the findings of the incident come from the outside investigator and they are allowed to make recommendations. The facility must conduct a Critical Incident Review within 30 days of the incident. The reports are provided to the PCM for review and whatever actions are necessary will be taken. The team will use the information from the incident for future trainings, and make changes of supervision if needed. There were three allegations of sexual abuse reported. Upon the conclusion of the investigation, the facility conducted the incident review utilizing the Critical Incident Review Form. The review occurred within 30 days of the conclusion of the investigation.

Two staff who are a part of the incident review team reported that facility takes into consideration whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, transgender, or intersex identification, status, or perceived status; gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. The facility does not have cameras therefore they will assess by talking to kids and staff and monitoring behaviors. Some of the ways that the facility assesses physical barriers is to: look for location, proximity and where staff are to the resident; look in the staff dorm and see if bed assignments were involved; talk to the parent; and look at what the resident was doing prior to the incident. The facility has a debriefing form and will look at any contributing factors. Staffing levels would be assessed by verifying schedules and staff to resident ratio. They would also look at shift logs

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.386 (e). Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that, the review team shall:

1. Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse;
2. Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; or, gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility;
3. Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;
4. Assess the adequacy of staffing levels in that area during different shifts;
5. Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and
6. Prepare a report of its findings utilizing *Critical Incident Review Form* F9-71.
7. Implement the recommendations for improvement or shall document its reasons for not doing so.

As reported in the PAQ, the Ft. Bellefontaine facility, implements the recommendations for improvement of documents its reasons for not doing so. There were three allegations of sexual abuse reported in the last 12 months. Upon the conclusion of the investigation, the facility conducted the incident review utilizing the Critical Incident Review Form. The review occurred within 30 days of the conclusion of the investigation.

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.387: Data collection

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.387 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

115.387 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? ☒ Yes ☐ No

115.387 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

115.387 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? ☒ Yes ☐ No

115.387 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☒ Yes ☐ No ☐ NA

115.387 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the

auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy 9.18, *Prison Rape Elimination Act (PREA)*
    c. Data Collection Instrument

Findings (By Provision):

115.387 (a/c). As reported in the PAQ, the Ft. Bellefontaine facility, reviewed data collected and aggregated under its direct control to assess and improve the effectiveness of the facility's sexual abuse prevention, detection, and response policies, practices, and training, including by identifying problem areas, taking corrective action on an ongoing basis. Policy 9.18, *Prison Rape Elimination Act (PREA)* states that, "Data collection, review for corrective action, storage, publication, and destruction:

a. DYS shall collect and aggregate incident-based sexual abuse data from DYS and contractual residential facilities at least annually.
b. DYS shall review data collected to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training to include identifying problem areas and taking corrective action as necessary.
c. DYS will prepare an annual report of its findings and corrective actions for each facility, as well as DYS as a whole *(p. 17)*."

115.387 (b). As reported in the PAQ, the agency aggregates incident-based sexual abuse data annually. Per Policy 9.18, *Prison Rape Elimination Act (PREA)*, the facility will prepare annual reports. This report will include the identification of findings and corrective action plans.

115.387 (d). As reported in the PAQ, the agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that:
DYS will prepare an annual report of its findings and corrective actions for each facility, as well as DYS as a whole.

1. Such report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the DYS's progress in addressing sexual abuse.
2. DYS's report shall be approved by director and made readily available to the public through its website or, if it does not have one, through other means.
3. DYS may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility but must indicate the nature of the material redacted *(p. 18).*

115.387 (e.) Policy 9.18, *Prison Rape Elimination Act (PREA)* states that, "Data collection, review for corrective action, storage, publication, and destruction:

a. DYS shall collect and aggregate incident-based sexual abuse data from DYS and contractual residential facilities at least annually.
b. DYS shall review data collected to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training to include identifying problem areas and taking corrective action as necessary.
c. DYS will prepare an annual report of its findings and corrective actions for each facility, as well as DYS as a whole *(pp. 17-18)*."

115.387 (f). As reported in the PAQ, the agency has not been requested to provide the Department of Justice (DOJ) with data from the previous calendar year.

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.388: Data review for corrective action

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.388 (a)

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.388 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☒ Yes ☐ No

115.388 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.388 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy 9.18, *Prison Rape Elimination Act (PREA)*
    c. DYS Annual Report-Findings and Corrective Action 2019
    d. Data Collection Instrument
2. Interviews:
    a. Agency head
    b. PREA coordinator
    c. PREA compliance manager

Findings (By Provision):

115.388 (a). As reported in the PAQ, the agency reviews data collected and aggregated pursuant 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training, including:

- Identified problem areas;
- Taking corrective action on an ongoing basis; and
- Preparing an annual report of its findings from its data review and corrective actions for each facility, as well as the agency as a whole.

Policy 9.18, *Prison Rape Elimination Act (PREA)* states that, "Data collection, review for corrective action, storage, publication, and destruction:

a. DYS shall collect and aggregate incident-based sexual abuse data from DYS and contractual residential facilities at least annually.

b. DYS shall review data collected to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training to include identifying problem areas and taking corrective action as necessary.
c. DYS will prepare an annual report of its findings and corrective actions for each facility, as well as DYS as a whole (*pp. 17-18)*."

The interviewed agency head stated that "we conduct an incident review team meeting on all allegation of sexual abuse that are unsubstantiated or substantiated. The Regional Supervisor is part of the IRT, which includes staff from the facility on all levels. This information is forwarded to my office and depending on the IRT an after-action plan is then required. The PREA coordinator, regional supervisor and I will meet to discuss what action is required."

The interviewed PREA coordinator stated that they will annually review PREA related allegations. The data is "retained electronically on secure drive with limited access. Data is retained for ten years from date of initial collection". Additionally, the agency takes corrective action on an ongoing basis, based on the data. It is "discussed during Statewide Leadership meetings then during regional management meetings. Individual or regional issues not systemic statewide are addressed by director with regional administrator". The interviewed PREA coordinator reported that the agency prepares an annual report by reviewing "aggregated sexual abuse data, from facilities under its DYS control and contracted private are made available to the public through the DSS internet page at least annually".

The interviewed PREA compliance manager reported that the Ft. Bellefontaine facility reviews data collected and aggregated to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training.

A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.388 (b). As reported in the PAQ, the annual report indicates a comparison of the current year's data and corrective actions to those from prior years.

115.388 (c). As reported in the PAQ, the agency makes its annual report readily available to the public, at least annually, through its website. The agency head further confirmed that the reports are made public.

115.388 (d). When complete, the above-mentioned reports, names and descriptors are not used in the annual summary. The material not included in the annual summary is noted on the facility website. Policy 9.18, *Prison Rape Elimination Act (PREA)* states that, "Data collection, review for corrective action, storage, publication, and destruction:

a. DYS shall collect and aggregate incident-based sexual abuse data from DYS and contractual residential facilities at least annually.
b. DYS shall review data collected to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training to include identifying problem areas and taking corrective action as necessary.
c. DYS will prepare an annual report of its findings and corrective actions for each facility, as well as DYS as a whole *(p. 17-18)."*

The interviewed PREA coordinator stated that "the agency can redact material from our annual report if there is a threat to the safety and security of the facility and we have to make it known the nature of what's being redacted. Information that will and can be redacted is name and resident employees."

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.389: Data storage, publication, and destruction

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.389 (a)

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained? ☒ Yes ☐ No

115.389 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.389 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.389 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

Findings (By Provision):

115.389 (a). The Ft. Bellefontaine facility reported in the PAQ that incident-based and aggregate data is securely retained. Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that "DYS shall ensure that data collected are securely retained" *(p. 18).*

The interviewed PREA coordinator, reported that the agency collects data and the data is securely retained. It is retained electronically on secure drive with limited access. Data is retained for ten years from date of initial collection. The agency takes corrective action on an ongoing basis, the corrective action is discussed during Statewide Leadership meetings then during regional management meetings. Individual or regional issues not systemic statewide are addressed by director with regional administrator.

115.389 (b). Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that "DYS shall make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public through the DSS internet page at least annually" *(p. 18).*

115.389 (c). As reported in the PAQ, the facility shall remove all personal identifiers before making aggregate sexual abuse data public. Policy 9.18, *Prison Rape Elimination Act (PREA)*, states that "DYS may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility but must indicate the nature of the material redacted" *(p. 18)*.

115.389 (d). Policy 9.18, *Prison Rape Elimination Act (PREA)* indicates that "DYS shall maintain sexual abuse data for at least 10 years after the date of its initial collection." *(p. 18)*.

Corrective Action:

No corrective action is recommended for this standard.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard*.) ☐ Yes ☒ No

- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☒ Yes ☐ No ☐ NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with residents? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Policy 9.18, *Prison Rape Elimination Act (PREA)*
2. Interviews:
    a. PREA coordinator

Findings (By Provision):

115.401 (a). Policy 9.18, *Prison Rape Elimination Act (PREA)* states that "Audits**:** contents, findings, corrective action plan and appeals:

1. DYS shall adhere to frequency and scope of audits in accordance with PREA Standard 115.393.
2. DYS shall ensure that the auditor's final report is published on DSS internet page *(p.18*)."

115.401 (b). As reported by the PREA coordinator, the Ft. Bellefontaine facility is the only facility operated by the governing agency.

115.401 (h). During the inspection of the physical plant the auditor and was escorted throughout the facility by the manager. The auditor was provided unfettered access throughout the institution. Specifically, the auditor was not barred or deterred entry to any areas. The auditor had the ability to freely observe, with entry provided to all areas without prohibition. Based on review of documentation the facility is compliant with the intent of the provision.

115.401 (i). During the on-site visit, the auditor was provided access to any and all documents requested. All documents requested were received to include, but not limited to: employee and resident files, sensitive documents, and investigation reports. Based on review of documentation the facility is compliant with the intent of the provision.

115.401 (m). The auditor was provided private rooms throughout the facility to conduct resident interviews. The staff staged the residents in a fashion that the auditor did not have to wait between interviews. The rooms provided for resident interviews were soundproof and somewhat visually confidential from other residents which was judged to have provided an environment in which the offenders felt comfortable to openly share PREA-related content during interview. It should also be noted

that additional precautionary measures were taken to ensure proper social distancing due to the COVID-19.

A review of the appropriate documentation and interviews with staff indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.401 (n). Residents were able to submit confidential information via written letters to the auditor PO Box or during the interviews with the auditor. The auditor did not receive any correspondence from the residents of the Ft. Bellefontaine facility.

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.403: Audit contents and findings

All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Agency website: http://dss.mo.gov/reports/prison-rape-elimination-act-reports/

Findings (By Provision):

115.403 (f). Policy 9.18, *Prison Rape Elimination Act (PREA)* states that "Audits**:** contents, findings, corrective action plan and appeals:

1. DYS shall adhere to frequency and scope of audits in accordance with PREA Standard 115.393.
2. DYS shall ensure that the auditor's final report is published on DSS internet page *(p.18)."*

Corrective Action:

No corrective action is recommended for this standard**.**

AUDITOR CERTIFICATION

I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Latera M. Davis 5/22/2021

Auditor Signature **Date**

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.