Prison Rape Elimination Act (PREA) Audit Report

Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Report August 24, 2020

Auditor Information

Name: Dwight L. Fondren	**Email:** fondu714@hotmail.com
Company Name: Correctional Management and Communication Group LLC.	
Mailing Address: 6208 NW 78th Street	**City, State, Zip:** Kansas City, MO 64151
Telephone: 816-699-0244	**Date of Facility Visit:** July 28, 2020

Agency Information

Name of Agency Missouri Division of Youth Service		**Governing Authority or Parent Agency** *(If Applicable)* Department of Social Services	
Physical Address: 3418 Knipp Dr., Ste. A-1		**City, State, Zip:** Jefferson City, MO 65109	
Mailing Address: SAME		**City, State, Zip:** Same	
Telephone: 573-751-3324		**Is Agency accredited by any organization?** ☐ Yes ☒ No	
The Agency Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☒ State	☐ Federal

Agency mission: Division of Youth Services Mission Statement: The mission of the Division of Youth Services is to enable youth to fulfill their needs in a responsible manner within the context of and with respect for the needs of the family and the community.

Agency Website with PREA Information: https://dss.mo.gov/dys/

Agency Chief Executive Officer

Name: Scott Odum	**Title:** Division Director
Email: scott.odum@dss.mo.gov	**Telephone:** 573-751-3324

Agency-Wide PREA Coordinator

Name: Judy Parrett	**Title:** Project Consultant
Email: judyparrett@dss.mo.gov	**Telephone:** 573-751-3324
PREA Coordinator Reports to: Scott Odum	**Number of Compliance Managers who report to the PREA Coordinator** 27

Facility Information

Name of Facility: Mt. Vernon Treatment Center (MTVTC)				
Physical Address: 500 State Drive Mt. Vernon, MO 64062				
Mailing Address (if different than above): SAME				
Telephone Number: 471-466-0892				
The Facility Is:	☐ Military	☐ Private for Profit	☐ Private not for Profit	
☐ Municipal	☐ County	☒ State	☐ Federal	
Facility Type:	☐ Detention	☒ Correction	☐ Intake	☐ Other
Facility Mission: The mission of the Division of Youth Services is to enable youth to fulfill their needs in a responsible manner within the context of and with respect for the needs of the family and the community. The mission of the Mt. Vernon is to enable all youth assigned at their site to fulfill their needs in a responsible manner within the context of and with respect for the needs of the family and the community.				
Facility Website with PREA Information: https://dss.mo.gov/dys/				
Is this facility accredited by any other organization? ☐ Yes ☒ No				

Name: Chad Irwin	**Title:** Youth Facility Manager
Email: chad.irwin@dss.mo.gov	**Telephone:** 471-466-0892

Facility PREA Compliance Manager

Name: Chad Irwin	**Title:** Youth Facility Manager
Email: chad.irwin@dss.mo.gov ov	**Telephone:** 471-466-0892

Facility Health Service Administrator

Name: Tracy O'Hara	**Title:** RN
Email: tracy.d.o'hara@dss.mo.gov	**Telephone:** 471-466-0892

Facility Characteristics

Designated Facility Capacity: 36	**Current Population of Facility:** 18
Number of residents admitted to facility during the past 12 months	51
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:	45
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:	51
Number of residents on date of audit who were admitted to facility prior to August 20, 2012:	0
Age Range of Population:	14-16
Average length of stay or time under supervision:	156 days
Facility Security Level:	Medium Security
Resident Custody Levels:	Medium Security
Number of staff currently employed by the facility who may have contact with residents:	53
Number of staff hired by the facility during the past 12 months who may have contact with residents:	11
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	1

Physical Plant

Number of Buildings: 4	**Number of Single Cell Housing Units:** 0
Number of Multiple Occupancy Cell Housing Units:	0
Number of Open Bay/Dorm Housing Units:	3
Number of Segregation Cells (Administrative and Disciplinary:	0

Description of any video or electronic monitoring technology (including any relevant information about where cameras are placed, where the control room is, retention of video, etc.): During the tour, there were cameras observed throughout the facility to include resident sleeping areas and program areas. The Youth Facility Manager stated that there are plans to install additional video or electronic monitoring systems.

Medical

Type of Medical Facility: None	General medical services are provided weekly by RN and Monthly by Dr. Outside Local Medical Facility is available for emergency requirements.
Forensic sexual assault medical exams are conducted at:	Outside medical facility in close proximity to facility

Other

Number of volunteers and individual contractors, who may have contact with residents, currently authorized to enter the facility:	8
Number of investigators the agency currently employs to investigate allegations of sexual abuse:	0

Audit Findings

Audit Narrative

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.

Audit Methodology

Pre-Onsite Audit Phase

Missouri Division of Youth Services Agency PREA Coordinator (APC), designated facility management staff and the Auditor had discussions concerning access to the facility, staff, residents the audit process, the logistics for the onsite phase of the audit, and goals and expectations prior to the site visit. The PREA Auditor also contacted the Youth Facility Manager (YFM/PCM) directly to discuss access to the facility, staff, resident's interview and audit process. The YFM serves as the Facility's PREA Compliance Manager (FPCM). The YFM/PCM was very receptive to the audit process and well informed of the role of the Auditor and the expectations during each stage of the PREA audit.

The notification of the on-site audit at Mt Vernon Treatment Center (MTVTC) was posted on June 18, 2020, six weeks prior to the date of the onsite audit. The posting of the notices was verified by photographs received electronically from the APC. The photographs indicated notices were posted strategically throughout the facility accessible to residents, staff, visitors, contractors, and volunteers to include living units, and common areas. The posted audit notices contained the Auditor's contact information and included information regarding confidentiality. The notice was posted in English and Spanish and at eye levels easy for a person to see either standing or sitting. All residents in the facility during the time of the site visit spoke and read English. The completed PREA Pre-Audit Questionnaire, policies and procedures, and supporting documentation were uploaded to a flash drive and mailed to the Auditor. An initial assessment was conducted of the information provided and it was determined the information was provided in detail on the flash drive. The documentation on the flash drive was well organized by each standard, including the identified provisions of each standard.

Onsite Audit Phase

The on-site visit was conducted July 28-29, 2020 by Dwight L. Fondren (Auditor). The Auditor arrived onsite during the early morning hours in order to interview some staff members on the overnight shift and observe early morning operations. MTVTC random staff members were interviewed immediately upon the Auditors' arrival to the facility to reduce the accrual of overtime hours. An entrance conference was conducted that included the Youth Facility Manager, the Assistant Regional Administrator, and the Auditor. After the formal introductions the Auditor discussed the information contained in the PAQ and a review of the audit process. Additionally, interview protocols to be used by the Auditor to interview random staff and residents as part of the audit were discussed. Policy documentation, relevant observations, the interview protocols, and the audit compliance tool were used to establish evidence of standard compliance. Additional information requested during the site visit was provided or explained by the Youth Facility Manager/PCM.

Upon completion of the entrance conference, a comprehensive site review of the facility was conducted and led by the FPCM. The tour included all areas of the facility. The facility was very clean, in good repair, and well maintained. All areas were viewed, including the administration area, medical area, intake area, kitchen, dining room/visitation area, leisure/recreation areas, and the living units area.

PREA-related informational posters and the PREA audit notice were observed posted throughout the facility. Additionally, informational pamphlets about PREA were found in areas where staff and youth have access. The notices contained large enough print to make them accessible and easy to see and read and in English and Spanish. Posted signs were observed regarding general PREA information including emergency and non-emergency numbers for assistance. The posted information included instructions on accessing the hotline for reporting allegations and requesting advocacy services. Questions were answered by staff during informal interviews regarding resident activities and program services as the site review progressed throughout the facility. Designated telephones identified for confidential calls (to include PREA, legal and other personal calls) were inspected and were in working order. The reporting process was discussed during the site review and instructions for accessing the child abuse and neglect hotline were posted.

Interviews

The Auditor used staff and inmate population rosters to identify staff members who served and performed in specific PREA related specialized roles within the facility, information regarding residents who may be in vulnerable categories such as disabled; limited English proficient; intersex, gay, lesbian, bisexual and/or transgender residents. In addition attendance records and rosters were used to identify potential interviewees. As a result of the information received, the Auditor developed an interview schedule of specialized and random staff and random and targeted residents, for interview requirement information and comments.

Fifty-three staff is currently employed at the facility that may have contact with residents. Several MTVTC staff provides dual services and roles in the management of the PREA Programs. A total of 30 staff interviews were conducted to include the Youth Facility Manager/PCM; Youth Group Leader, Youth Specialist I & II (from all three 8-hour shifts); an intermediate/upper management staff; specialized staff, and random staff. The random staff members interviewed covered all shifts and specialized staff members interviewed was based on their job duties and PREA roles. Although 14 individuals were identified for specialized interviews, the specialized interviews conducted included staff members in this category serving in more than one PREA related specialized role. The interviews with staff indicated their receipt of PREA training, which was also verified by a review of documentation, including training materials. The resident Daily Roster provided indicated that there were 18 residents at the start of the site visit. A total of 13 resident interviews were conducted and included anyone in the targeted categories. Interviews with the residents included 4 individuals in the target category that may have identified in more than one PREA related targeted group.

Staff and resident interviews conducted by the Auditor were done in the privacy of a conference room. Masks were used by staff and the Auditor. All Resident interviews were conducted utilizing established “social distance protocols.” During this process the Auditor did not limit the interview questions to only those included in the protocols; rather, additional site-specific questions were asked to use as a starting point for eliciting information about the facility’s compliance with the PREA Standards. All responses to the interview questions were part of the Auditor’s compliance assessment. There are no on-site medical providers at the center. Resident interviews support staff’s compliance with the facility’s prohibition of cross-gender viewing and pat searches. This Auditor was provided evidence to ensure compliance to the PREA as documented in this report.

The following resident categories were recommended during the onsite phase of the audit:

Category of Residents	Number of Interviews
Random Residents	9
Residents who Identify as Gay or Bisexual	1
Residents with a Cognitive Disability	0
Residents Report of Sexual Abuse at this Facility	0

Residents with Physical Disability	0
Residents Report of Sexual Abuse	3
Residents who Identify as Transgender or Intersex	0

The Auditor conducted the following number of specialized staff category interviews during the onsite phase of the audit:

Category of Staff	Number of Interviews
Medical Staff	1
Mental Health Staff	0
Administrative (Human Resources) Staff	1
Intermediate or Higher-level Facility Staff (unannounced rounds)	1
Volunteers who have Contact with Residents	0
Contractors who have Contact with Residents	0
Investigative Staff	0
Staff who Perform Screening for Risk of Victimization and Abusiveness	1
Staff on the Incident Review Team	2
Designated Staff Member Charged with Monitoring Retaliation	1
Security Staff First Responders	1
Non-Security Staff First Responders	0
Intake Staff	3
Education and Program Staff who works with Youthful Offenders	3
Number of Specialized Staff Interviews	14*
Number of Random Staff Interviews	14
Total Random and Specialized Interviews	28
Total Interviews plus PREA Coordinator and Director	30

(*) The specialized interviews conducted included staff members in this category serving in more than one PREA related specialized role.

Onsite Documentation Review

The Auditor received many examples of documentation from resident and staff files as part of the Pre-Onsite Audit Phase. During the pre-onsite audit phase and the onsite audit phase, the Auditor reviewed a sample of training and personnel files of the staff selected to be interviewed, including documentation of criminal background checks. The PREA Pre-Audit Questionnaire and facility policies, procedures and supporting documentation were reviewed prior to the site visit and while onsite for interviewees and persons not interviewed. The secondary documentation reviewed included, but was not limited to, PREA Vulnerability Information Review (PVIR) forms, Grievance forms, Safety First Training Records Youth Handbook Signatures, Facility Health Screening forms and Initial Health Screening Forms, annual staffing plan assessment, staff schedules, unannounced rounds reports, organization chart, and other documentation. The facility reports there were zero allegations of sexual abuse or sexual harassment in the past 12 months.

After the completion of the site visit process, an exit briefing was held. The attendees were the, Assistant Regional Director, Youth Facility Manager II, the Assistant Facility Manager, the Senior Support Assistant, the Agency PREA Coordinator,(via telephone) and the Auditor. The exit briefing served to review the onsite process and review program strengths. The YFM/PCM was given the opportunity to ask additional questions about the activities of the day and the shared information. The time table for the submission of PREA Report was discussed as well.

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 programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

Mt. Vernon Treatment Center is located in Mt. Vernon, Missouri on approximately 11 acres. The program was built in 1998, designed with a capacity of thirty-six (36) male residents and is the largest DYS program in the Southwest Region. Mt. Vernon Treatment Center has a total of ten (10) buildings on the grounds. There are two (2) sheds, one (1) Office of Administration (OA) maintenance building, one (1) storage building, one (1) vocational shop and one (1) pole barn that are located outside the fence on the property. They are all used for storage with the exception of the OA building and the vocational shop. Residents that have shown readiness participate in the vocational shop. Inside the secure fenced area are four (4) buildings with a courtyard area. The main administrative building has a secure entrance/check-in area, a large conference room, the gym/cafeteria, administrative offices, family therapy room, education office, medical office, three (3) classrooms and a computer lab, student library, storage closets, student and visitor/staff bathrooms and outdoor recreation area (basketball court, sand volleyball court, garden area, fire pit with seating and softball field). The other three (3) buildings are dormitories. At the entrance of each dormitory is a patio area that enters into a living area with twelve (12) bunk beds each, treatment/group area, bathroom/shower area, laundry area, staff office and group leader's office.

Summary of Audit Findings

*The summary should include the number of standards exceeded, number of standards met, and number of standards not met, **along with a list of each of the standards in each category**. If relevant, provide a summarized description of the corrective action plan, including deficiencies observed, recommendations made, actions taken by the agency, relevant timelines, and methods used by the auditor to reassess compliance.*

Mt. Vernon Treatment Center is a 36 bed secure moderate care male residential facility governed by the Missouri Division of Youth Services (DYS), a division of the Missouri Department of Social Services. The residents have been committed to the care and custody of the Division of Youth Services through the juvenile court system. Mt. Vernon Treatment Center serves residents from the twenty-seven (27) counties of the Southwest Region. Generally, residents are committed to this facility for offenses ranging from property damage, physical and sexual harming, etc., and many residents in care have experienced prior out of home placements. The length of stay in the program is based upon residents completing their individual treatment goals and program expectations; however, the average length of stay is four to six months. A service coordinator determines resident's treatment needs and ensures continuity of treatment services from intake to release. Also, the facility services are supplemented by DYS Family Specialists, Treatment Coordinators, a Regional Clinical Coordinator, and Community Mentors. The facility has three (3) groups of male residents generally ranging in age from 14-16 years. There were thirty-one (31) male residents at the facility at the time of the review.

The facility is staffed with fifty-three (53) full-time and part-time staff. The staff consisted of a Youth Facility Manager, Assistant Youth Facility Manager, Group Leaders, Youth Specialists, Academic/Special Ed Teachers, Vocational Teacher, Education Assistant, Outdoor Rehabilitation Counselor, other staff (Administrative and Food Service), and Liaison Counselor volunteers. In addition,

to the full-time and part-time employees there is maintenance provided by the Office of Administration. The medical staff consists of a full-time registered nurse (RN) under the guidance of a licensed regional registered nurse providing nursing services on-site Monday – Friday (9:00 am – 5:00 pm), available 24/7, and an on-call physician. The facility has contracts with the local hospital for 24 hour emergency needs. A nurse practitioner visits the facility once a week. Also, psychiatric services provided via telehealth with a licensed adolescent psychiatrist in addition to the nurse providing health education and counseling about a variety of health topics. The medical staff provides medical care to include: completing the initial intake assessment, review intake referrals, routine and additional lab work as ordered, STD testing and treatment as indicated, updating immunization records, seasonal flu vaccinations, routine eye exams, dietary services and referrals, administration of medications and treatments as prescribed, assessments of resident injuries and treatment as required, medical assessments and monitoring with any restraint or seclusion, assessments of somatic health complaints with treatment as indicated, develop treatment plans and provide medical discharge plans. Several on-site medical clinics occur including a weekly medical clinic, a weekly mental health clinic, and participation in weekly treatment planning meetings. The dental services are provided off campus and consist of dental care, cleaning, education, and treatment fillings to extractions. All residents are seen by the dentist at least annually for a wellness check. The facility has contracted an optometrist who provides routine eye exams.

The school operates with certified teachers and provides state accredited educational services for the residents. This allows residents to continue their education while receiving assistance and support with their treatment needs while at the program. DYS provides educational services accredited by the Missouri Department of Elementary and Secondary Education (DESE). Each resident receives educational services guided by a personalized education plan developed by the DYS education staff, the student and his parent/guardian. The educational staff addresses the academic, emotional, physical, and social needs of the residents by offering them a variety of programs and services that elicit the maximum potential of each student. The objectives for learning are emphasized for each resident in DYS care as follows: Re-mediate deficiencies in learning skills and academic knowledge; Connect learning to responsible citizenship and self-sufficiency; Recover academic standing and units of high school credit; learn the value and importance of a good education; Increase self-confidence and self-esteem and Improve behavior and study skills.

Students are assigned a full-day schedule of classes and follow a twelve (12) month school calendar. The facility's educational program includes classroom(s) suitable for interactive learning activities; literacy, career and research centers; up-to-date instructional materials; and technology necessary for learning. The educational staff's instruction consists of: language arts, mathematics, science, social studies, fine arts, career education, personal finance, health and physical education. In addition, students study Missouri and U.S. government and complete the required Missouri and U.S. constitution test(s). The DYS instructional curriculum outlines the key concepts and course goals for these subjects and electives establishing a foundation of knowledge as it develops the skills necessary for students to think, reason, create, communicate and live in an ever-changing technological society. The educational staff recognizes the importance of completing a challenging program of education. Every student is encouraged to complete their education by returning to public schools, graduating while in group home, obtaining a GED or prepare for college through taking their ACT. While at the group, some students meet Missouri and DYS graduation requirements. Special Education services are offered to students who qualify and counseling services are offered to all students. Residents who receive special education services are provided by certified, special needs instructors. The school is equipped with a full service library including technological equipment to enhance student learning.

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 residents in care at the facility. Mt. Vernon Treatment Center operates from a treatment program called the Circle of Courage. It is a Native American philosophy that honors four (4) Values that are

critical in working with the residents. These Values are: The Value of Belonging, The Value of Mastery, The Value of Generosity, and the Value of Independence. Residents explore the different Values while they are at the facility to increase their confidence, understanding and application of these Values. The facility environment is based upon maintaining safety, cleanliness, and organization always within a structured, positive, and supportive environment. Treatment goals and objectives are developed in the context of resident's and family's strengths and assets, are trauma informed, incorporate positive youth development principles within the framework of well-being including mastery, stability, safety, access to mainstream relevant resources, and social connections.

Due to the COVID-19 Precautions initiatives, on-site visits have been cancelled. However, the FYM stated that the family plays a vital role in each resident's treatment process so the facility has increased weekly phone calls and written correspondence with family members, legal guardians and others who are a part of the resident's overall support system as well as utilizing online visitation efforts.

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

Number of Standards Exceeded: 0

N/A

Number of Standards Met: 43

Based upon the review and analysis of the documentation, interviews and observations, the Auditor has determined the facility is compliant with the PREA Standards for Juvenile Facilities.

Number of Standards Not Met: 0

Summary of Corrective Action (if any)

No Corrective Actions were required.

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.

Documentation Reviewed:
Missouri Division of Youth Services (DYS) Policy 9.18 (Prison Rape Elimination Act of 2003);
DYS Policy 9.28 (Developing Relationships);
DYS Policy Policy 3.23 (Ethical Standards of Employee/Youth Relations)
Department of Social Services/Division of Youth Services/Mt. Vernon Organizational Chart
PREA Pre-Audit Questionnaire

Interviews:
Youth Facility Manager/PCM
Regional Administrator
Random Staff

Provision (a):
An agency shall have a written policy mandating zero-tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency's approach to preventing, detecting, and responding to such conduct.

The facility Policy mandates a zero-tolerance policy toward all forms of sexual abuse and sexual harassment. The policy outlines the facility's approach to preventing, detecting, and responding to such conduct. The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment and includes sanctions for those found to have participated in prohibited behaviors. The Policy addresses detection of sexual abuse and sexual harassment through resident education, staff training, and intake screening for risk of sexual victimization and abusiveness. The Policy includes, but is not limited to, responding to sexual abuse and sexual harassment through reporting, investigations, assessments and crisis intervention.

Provision (b):
An agency shall employ or designate an upper-level, agency-wide PREA Coordinator with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities.

The Agency Policy indicated a designated position, PREA Coordinator (APC). The interview with the Youth Facility Manager (FPCM), Assistant Regional Administrator and a review of the Department of Social Services/Division of Youth Services Organizational Chart, revealed that the agency has a designated Agency PREA Coordinator. The PREA Coordinator works statewide to implement the PREA Standards and indicated that she has sufficient time and authority to develop, implement and oversee the agency's efforts toward PREA compliance of their residential facilities.

Provision (c):
Where an agency operates more than one facility, each facility shall designate a PREA compliance manager with sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards.

The Agency Policy indicated a designated position, PREA Compliance Manager (PCM). The interview with the Youth Facility Manager revealed that the Youth Facility Manager (FYM) is also the designated Facility PREA Compliance Manager (FPCM). During his interview the FYM indicated he has sufficient time and authority to develop, implement and oversee the facility's efforts to comply with the PREA standards.

Conclusion:
Based upon the review and analysis of the available documentation, the Auditor has determined the facility is compliant with this standard requiring a zero-tolerance policy toward sexual abuse and sexual harassment and the designation of a PREA Coordinator and PREA Compliance Manager.

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 OR the response to 115.312(a)-1 is "NO".) ☒ 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.

Provision (a & b):
An interview with the YFM/PCM revealed that the State of Missouri Department of Social Services has contracts with judicial districts for the purpose of securing Reception and Detention (R&D) services to support the work of the state agency. DYS policy 9.18 Prison Rape Elimination Act of 2003 indicate that the agency shall include in any new reception and detention contract or renewal of existing contract, the entity's obligation to adopt and comply with the PREA standards and shall provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards.

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 agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards? ☒ Yes ☐ No

- Does the agency ensure that each facility's staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: 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 only until October 1, 2017.) ☒ 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 only until October 1, 2017.) ☒ 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 only until October 1, 2017.) ☒ Yes ☐ No ☐ NA

- Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.) ☒ 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.

Documents Reviewed:
Missouri Division of Youth Services (DYS) 9.18 PREA Sec.111A2
Missouri Division of Youth Services (DYS) 9.6 Program Supervision Sec.111A1
MTVTC MDYS Staffing Plan Annual Evaluation Report 2019
MTVTC Unannounced Rounds Documentation
PREA Pre-Audit Questionnaire

Interviews:
Youth Facility Manager/PCM
Random Staff

Provision (a):
The agency shall ensure that each facility it operates shall develop, implement, and document a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, facilities shall take into consideration:
(1) Generally accepted detention and correctional/secure residential practices;
(2) Any judicial findings of inadequacy;
(3) Any findings of inadequacy from Federal investigative agencies;
(4) Any findings of inadequacy from internal or external oversight bodies;
(5) All components of the facility's physical plant (including "blind spots" or areas where staff or residents may be isolated);
(6) The composition of the resident population;
(7) The number and placement of supervisory staff;
(8) Institution programs occurring on a particular shift;
(9) Any applicable State or local laws, regulations, or standards;
(10) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and
(11) Any other relevant factors.

The Facility Policy provides details for maintaining the staffing ratios. The MTVTC staff schedules reviewed indicated that the facility has a variety of shifts for the Group Leaders and Youth Specialists that provides for adequate levels of staffing, and monitoring, to protect residents against sexual abuse. The Facility has three cottages with one in-active at the time of the PREA On-site Audit. One cottage had 10 residents and the other cottage had 8 residents. There were a minimum of two staff three staff on duty on each shift and in both cottages. The MTVTC shifts included 8am-4pm; 8am-4pm; 4pm-12am; 12am-8am; 3pm. In addition, there is generally a Group Leader on each shift. The DYS PREA Policy provides for a staff-to-resident ratio of 1:6 during the waking hours and sleeping hours. The staff-to-resident ratio was complying during the comprehensive site review. PREA training is required of all new hires, as well as PREA refresher courses provided throughout the year to better ensure resident safety.

Provision (b):
The agency shall comply with the staffing plan except during limited and discrete exigent circumstances, and shall fully document deviations from the plan during such circumstances.

The facility Policy states in the event that the staffing ratio is unable to be maintained during exigent circumstances, the deviation must be documented. The facility documents there have been no deviations to the staffing plan in the past 12 months. The facility is prepared to document any deviations from the staffing plan.

Provision (c):
Whenever necessary, but no less frequently than once each year, for each facility the agency operates, in consultation with the YFM/PCM required by § 115.311, the agency shall assess, determine, and document whether adjustments are needed to:
(1) The staffing plan established pursuant to paragraph (a) of this section;
(2) Prevailing staffing patterns;
(3) The facility's deployment of video monitoring systems and other monitoring technologies; and
(4) The resources the facility has available to commit to ensure adherence to the staffing plan.

DYS PREA Policy provides, at the least, an annual assessment of the staffing plan is conducted. The Staffing Plan Assessment is conducted annually with the latest being conducted in December 2019. The FYM stated that in developing the plan, staff management reviews areas such the prevailing

staffing patterns; deployment of mirrors or video monitoring systems as needed; and occurrence of unannounced rounds.

Provision (d):
In the past 12 months, the facility, in consultation with the agency PREA Coordinator, shall assess, determined, and documented whether adjustments are needed to the staffing plan established pursuant to paragraph (a) of this section; to prevailing staffing patterns; to the facility's deployment of video monitoring systems and other monitoring technologies and to the resources the facility has available to commit to ensure adherence to the staffing plan.

A review of the MDYS policy, the facility Staffing Plan and the unannounced procedures, it was determined that the facility has assessed, determined, and documented whether adjustments were needed to the staffing plan established pursuant to paragraph (a) of this section over the past 12 months. The YFM and PCM stated that the deployment of video monitoring systems and other monitoring technologies and resources for the facility are discussed to ensure adherence to the staffing plan was considered.

Provision (e):
The facility shall implement 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. The policy and practice should be implemented for night shifts as well as day shifts. In addition, the facility should 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.

A review of the (DYS) 9.18 PREA Sec.111A2, it was determined that the facility has 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. The policy and practice is implemented for night shifts as well as day shifts. Copies of the unannounced rounds conducted by the YFM/PCM/ were reviewed. In addition, the facility policy prohibits staff from alerting other staff members that these supervisory rounds are occurring.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is in compliance with this standard regarding supervision and monitoring.

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 implement policies and 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.

Documents Reviewed:
Missouri Division of Youth Services (DYS) 9.18 PREA Section I-III
DYS Policy 5.8 Searches for Contraband Section IIIE
DYS Policy 9.6 Program Supervision Section III
DYS Policy 7.2 Standards Section IIID1e
PREA Pre-Audit Questionnaire
MTVTC Staff Training Records
Cross Gender & Transgender Pat Search DYS Manual Overview
DYS Training Guide for Physical Searches of Youth in a Residential Setting

Interviews:
Youth Facility Manager/PCM
Random Staff
Random Residents

Provision (a):
The facility shall not conduct cross-gender strip searches or cross-gender visual body cavity searches (meaning a search of the anal or genital opening) except in exigent circumstances or when performed by medical practitioners.

DYS PREA Policy on Limits to Cross Gender Viewing and Searches prohibits cross-gender strip searches and cross-gender visual body cavity searches. There is no evidence of cross-gender strip searches or cross-gender visual body cavity searches occurring at the facility. Based on the review of the Pre-audit questionnaire and according to the YFM/PCM, no such searches have been conducted.

Provision (b):
The agency always refrains from conducting cross-gender pat-down searches of female residents, except in exigent circumstances. In addition, the agency shall always refrain from restricting female residents' access to regularly available programming or other outside opportunities in order to comply with this provision.

MDYS PREA Policy provides that staff will only conduct cross-gender pat-down searches of youth only in exigent circumstances. The YFM stated that there is an effort to ensure that both male and female staff is always on duty. No cross-gender pat down searches, or visual searches should ever occur unless in the rarest of exigent circumstances and only after contacting the YFM/PCM and the justification for the search must be documented. Interviews with Staff indicated that cross-gender pat-down searches have not occurred at the facility, but the facility is prepared for them to be conducted in exigent circumstances. Based on the review of the Pre-audit questionnaire; and staff interviews; training sign-in sheets; and training acknowledgement statements, the facility follows this provision of the standard.

Provision (c):
The facility shall document and justify all cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches.

The Policy prohibits cross-gender strip searches and cross-gender visual body cavity searches. Cross-gender pat-down searches may be conducted only in exigent circumstances which random staff interviews summarized as an extreme emergency. The Policy indicates that in the event a cross-gender search is warranted pursuant to an emergency circumstance; it must be approved by the YFM/PCM and the justification for the search documented. Such searches would be documented on a form currently used for all searches which have been used for same sex searches. The form requires the staff to record the reason for the search.

Provision (d):
The facility shall implement policies and 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. Such policies and procedures shall require staff of the opposite gender to announce their presence when entering a resident housing unit. In facilities (such as group homes) that do not contain discrete housing units, staff of the opposite gender shall be required to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing.

DYS PREA Policy states the facility will enable residents to shower, perform bodily functions, and change clothes without non-medical staff of the opposite gender viewing them except in exigent circumstances or during routine room checks. Staff members of the opposite gender are required to knock and/or announce themselves upon entering the unit. This practice was confirmed through observation of signage indicating such and interviews with staff.

Provision (e):
The facility shall not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined 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.

DYS Policy prohibits the search of transgender or intersex residents solely for the purpose of determining the residents' genital status. Staff interviews verified no such searches have occurred in the past 12 months. According to the Policy, if the resident's genital status is unknown, it may be determined during conversations with the resident, by reviewing medical records, or by learning that information as part of a broader medical examination conducted in private by a medical practitioner. Staff interviews confirmed they are aware facility policy prohibits them from conducting a physical examination of transgender or intersex resident solely for the purpose of determining the resident's genital status. Based on the documentation reviewed and staff interviews, the facility meets this provision of the standard.

Provision (f):
The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

DYS PREA Policy states that staff shall be trained in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs. The documentation and staff interviews

indicates that staff is trained in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

Conclusion:
Based on the reviewed documentation and interviews, the facility follows this provision of the standard.

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.

Documents Reviewed:
Missouri Division of Youth Services (DYS) Policy 9.18 PREA Section I-III (PREA) 2.17
DYS Statewide Contracts for Written, Sign & Verbal Language Interpretation Services
DYS Policy 5.8 Searches for Contraband Section III

Safety First Handbook/Pamphlets in English and Spanish
MDYS PREA Staff Training Outline

Interviews:
Random Staff
Random Residents
Youth Facility Manager/PCM

Provision (a):
The agency shall take appropriate steps to ensure that residents with disabilities (including, for example, residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech 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. Such steps shall include, when necessary to ensure effective communication with residents who are deaf or hard of hearing, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. In addition, the agency shall 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, limited reading skills, or who are blind or have low vision. An agency is not required to take actions that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens, as those terms are used in regulations promulgated under Title II of the Americans With Disabilities Act, 28 *CFR* 35.164.

The facility Policy addresses the provision of support services for disabled residents by providing these residents the equal opportunity to participate in or benefit from all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. The Policy prohibits use of 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, performance of first responder duties, or the investigation of the allegations. Staff interviews and an interview with a contractor confirmed this information.

Provision (b):
The agency shall 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, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary.

A Contract for Statewide Language Interpretation verbal, Telephone and Sign Language Services is available and can be accessed by staff 24/7. The Resident Handbook is in English and Spanish. The evidence shows residents with disabilities and who may be limited English proficient are provided 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. All staff interviewed confirmed residents are not used as interpreters and understand prior arrangements have been made regarding language interpreters. The Safety First Handbook/Pamphlets is printed in English and Spanish. The PREA audit notice was printed in English and Spanish. The evidence shows the facility ensures 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, including taking steps to provide interpreters who can interpret effectively, accurately, and impartially, using any necessary specialized vocabulary.

Provision (c):

The agency shall not rely 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.

According to Policy the facility prohibits the use of resident interpreters, resident readers or any kind of resident assistants except when a delay in obtaining interpreter services could jeopardize a resident's safety, performance of the first responder duties, or the investigation of the allegation. Staff interviews confirmed residents have not been used to relate PREA information to or from other residents in the past 12 months. There were no residents in need of an interpreter during the site visit.

Conclusion:
Based upon the review and analysis of the evidence, the Auditor has determined the facility is compliant with this standard regarding residents with disabilities and residents who are limited English Proficient. Residents with disabilities are provided 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.

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, or 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)

- Unless prohibited by law, 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.

Documentation Reviewed:
Missouri Division of Youth Services (DYS) 9.18 PREA Section I-III
DSS Policy 2-107 Background Checks
Missouri Division of Youth Services (DYS) Memo on Annual Background Check Results

Interviews:
Youth Facility Manager/PCM
Random Staff

Provision (a) & (f):
(a) The agency shall not hire or promote anyone who may have contact with residents, and shall not enlist 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 (as defined in 42 U.S.C. 1997);
(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, or 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.
(f) The agency shall also 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 and in any interviews or written self-evaluations conducted as part of

reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.

Facility Policy DYS 9.18 section IIIA5 addresses hiring and promotion processes and decisions and background checks. Agency policy prohibits hiring or promoting anyone who may have contact with residents who (1) has engaged in sexual abuse in a prison, jail, lockup, community confinement 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 threat of force, or coercion or if the victim did not consent or was unable to consent or refuse (3) Has been civilly or administratively adjudicated to have engaged in the activity described above.

The agency policy requires that a criminal background check records check be completed and applicable child abuse registries consulted before enlisting the services of any contractor who may have contact with residents. Agency requires that either criminal background check records checks be conducted at least annually for current employees and contractors who may have contact with residents or that a system is in place for otherwise capturing such information for current employees. Agency policy states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

Provision (b):
The agency shall consider any incident 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 facility Policy states any incidents of sexual harassment by a staff member will be taken into consideration if the staff member is eligible for promotion. The interview with the YFM/PCM was aligned with the standard. The interview questions for employment also address previous misconduct. The evidence shows the facility considers any incident 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. Based on the review of the personnel files, records provided during the pre-audit phase, and the interview with the YFM/PCM, the facility follows this provision of the standard.

Provisions (c) & (d):
(c) Before hiring new employees or (d) contractors who may have contact with residents, the agency shall:
(1) Perform a criminal background records check;
(2) Consult 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 agency policy requires background checks to occur prior to residents receiving services from contractors and volunteers and confirmed by the YFM/PCM's interview. Additionally, best efforts should be made 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. Based on the review of documentation and interview with the YFM/PCM, the facility follows this provision of the standard.

Provision (e):
The agency shall 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.

The agency policy is aligned with the requirements of the provisions of the standard and provides background checks occur prior to employment and annually thereafter. A review of documentation indicates that the Background check results are received and reviewed by DYS HR and DYS HR sends a clearance email to the facility notifying them they that the applicants background check is complete and the applicant is cleared to begin work/providing services.

Provision (g):
Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

Facility Policy states material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. Based on the review of the documentation and the interview with the YFM/PCM, the evidence shows the facility follows this provision of the standard.

Provision (h):
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.

The interview with the YFM/PCM confirmed the facility would provide this information if requested to do so. Facility Policy also states the information would be provided when requested unless it is prohibited by law to provide the information.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with the provisions of the standard regarding hiring and promotion decisions.

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.

Documentation Reviewed:
Missouri Division of Youth Services (DYS) Policy 9.18

Interviews:
Youth Facility Manager/PCM

Provision (a):
If the agency designed or acquired any new facility or planned any substantial expansion or modification of existing facilities, the agency must consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse.

N/A - The facility has not made a substantial expansion to existing facilities since the last PREA audit.

Provision (b):
If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, the agency should consider how such technology may enhance the agency's ability to protect residents from sexual abuse.

During the tour, there were cameras observed throughout the facility to include resident sleeping areas and program areas. The FYM provided the Auditor with a 2017 Upgrade list that identified repairs and maintenance needs. In 2018 upgrades and repairs were identified as well as additional needs that are being addressed as funds become available.

Conclusion:
A review of the staffing plans and the agency consideration of the effect of the facility design, or modification have enhanced the facility's ability to protect residents from sexual abuse and harassment.

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? ☒ Yes ☐ No

- 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 entity 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? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.) ☒ 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.

Documents Reviewed:
Missouri Division of Youth Services (DYS) 9.18 PREA Section I-III
Statewide Safe-Care Provider Listing for DYS
Missouri Department of Social Services DYS Critical Incident Report
Missouri Children's Division Out of Home Investigation Requirements (DYS External Investigations)
Agency Memo Agreement with the Victim Center

Interviews:
Medical Staff
Representative, Center for Counseling and Training (Advocacy Organization)
Youth Facility Manager/PCM

Provisions (a) & (b):
(a) To the extent the agency is responsible for investigating allegations of sexual abuse, the agency shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. (b) The protocol shall be developmentally appropriate for youth and, as appropriate, shall be 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.

The initial review of the Missouri Division of Youth Services (DYS) Policy 9.18 (Prison Rape Elimination Act of 2003) contained the elements of the standard and identified that all allegations of sexual abuse and sexual harassment be referred to the appropriate investigative agency based upon the victim's age. Additionally, policy requires protocols for informed consent, confidentiality, reporting to law enforcement, and reporting to child abuse investigative agencies. Documentation and some staff interviews confirmed the Missouri Children's Division Out-of-Home Investigation Unit (CD-OHI) conducts the administrative investigations of sexual abuse and sexual harassment allegations for residents under the age of 18 and they receive reports through their hotline.

Provision (c):
The agency shall offer all residents who experience sexual abuse access to forensic medical examinations whether on-site or at an outside facility, without financial cost, where evidentiary or medically appropriate.

Local Hospital (SAFE certified) provides the emergency and forensic medical examinations at no financial cost to the victim. Additionally, the Central Office has identified three (3) mental health professionals statewide that will serve as an advocate to link services and provide confidential emotional support to residents who are victims and/or report sexual abuse and sexual harassment by another resident, staff member, contractor or volunteer. These individuals are screened for appropriateness to serve as a victim advocate and receive specialized training. The Agency has a Memo Agreement with The Victim Center. The Victim Center has agreed to provide some services.

Provisions (d):
The agency shall attempt 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 agency shall make available to provide these services, a qualified staff member from a community-based organization or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified in 42 U.S.C. 14043g(b)(2)(C), to victims of sexual assault of all ages. The agency may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a nongovernmental entity that provides similar victim services.

As indicated by the Agency memo from the Victim Center, there are attempts to establish an memoranda with the Victim Center. Although they have agreed to provide some services they would not sign a MOU. According to the YFM/PCM, the Central Office has identified three (3) mental health

professionals statewide that will serve as an advocate to link services and provide confidential emotional support to residents who are victims and/or report sexual abuse and sexual harassment by another resident, staff member, contractor or volunteer.

Provisions (e):
As requested by the victim, the victim advocate, qualified agency staff member, or qualified community-based organization staff member 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.

Three (3) mental health professionals statewide has been identified that will serve as an advocate to link services and provide confidential emotional support to residents who are victims and/or report sexual abuse and sexual harassment.

Provisions (f):
To the extent the agency, itself, is not responsible for investigating allegations of sexual abuse, the agency shall request that the investigating agency follow the requirements of paragraphs (a) through (f) of this section. (g) The requirements of paragraphs (a) through (f) of this section shall also apply to: (1) Any State entity outside of the agency that is responsible for investigating allegations of sexual abuse in juvenile facilities; and (2) Any Department of Justice component that is responsible for investigating allegations of sexual abuse in juvenile facilities.

Policy requires protocols for reporting to law enforcement, and reporting to child abuse investigative agencies. Staff interviews confirmed the Missouri Children's Division Out-of-Home Investigation Unit (CD-OHI) conducts the administrative investigations of sexual abuse and sexual harassment allegations for residents under the age of 18 and they receive reports through their hotline. CD-OHI will contact the appropriate local law enforcement to co-investigate criminal allegations of sexual abuse. Residents 18 years of age are referred to the Division of Legal Services Investigation Unit (DLS) and appropriate law enforcement agency to co-investigate allegations of sexual abuse and sexual harassment.

Provisions (g):
Auditor is not required to audit this provision.

Provision (h):
For the purposes of this standard, a qualified agency staff member or a qualified community-based staff member shall be an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general.

The Central Office has identified mental health professionals statewide that will serve as an advocate to link services and provide confidential emotional support to residents who are victims and/or report sexual abuse and sexual harassment by another resident, staff member, contractor or volunteer. These individuals are screened for appropriateness to serve as a victim advocate and receive specialized training.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility follows the provisions of 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 such publication 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.

Documents Reviewed:
Missouri Division of Youth Services (DYS) 9.18 PREA Section I-III
DYS Policy 3.8 (Employee Conduct)
DYS Policy 6.1 Section III
DYS Mandatory Reporting Form/Hotline
DYS Fundamental Practices
Pre-Audit Questionnaire

Interviews:
Youth Facility Manager/PCM
Random Residents
Random Staff

Provision (a):
The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.

The Policy directs staff to report all allegations of sexual abuse and sexual harassment and to document the reports. When any physician, medical examiner, coroner, dentist, chiropractor, optometrist, podiatrist, resident, intern, nurse, hospital or clinic personnel that are engaged in the examination, care, treatment or research of persons, and any other health practitioner, psychologist, mental health professional, social worker, day care center worker or other child-care worker, juvenile officer, probation or parole officer, jail or detention center personnel, teacher, principal or other school official, minister, peace officer or law enforcement official, or other person with the responsibility for the care of children has reasonable cause to suspect that a child has been or may be subjected to abuse or neglect or observes a child being subjected to conditions or circumstances which would reasonably result in abuse or neglect, that person shall immediately report to the division in accordance with the provisions of sections 210.109 to 210.183.

Provision (b) and (c):
The agency shall have in place a policy 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. The agency shall publish such policy on its website or, if it does not have one, make the policy available through other means. The agency shall document all such referrals. (c): If a separate entity is responsible for conducting criminal investigations, such publication shall describe the responsibilities of both the agency and the investigating entity.

Whenever a DYS employee has reasonable cause to suspect an abusive or neglectful incident has occurred with a Youth under 18, the employee shall; immediately call the Children's Division (CD) Child Abuse and Neglect Hotline (1-800-392-3738). The employee should then notify the supervisor or designee that the report has been made. (Note: In instances wherein the supervisor designee is believed to be the perpetrator, the employee shall notify the supervisor or designee at the next appropriate supervisory level.) When Youth are 18 and older, reports will be made to the Division HR manager or personnel officer.

Provision (d):
Auditor is not required to audit this provision.

Provision (e):
Auditor is not required to audit this provision.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding policies to ensure referrals of allegations for investigations.

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.

Documents Reviewed:
Missouri Division of Youth Services (DYS) 9.18 PREA Section I-III
DYS Policy 3.18 Training Sec IIIB2a

PREA Staff Training Outline “The Care and Treatment of Our Youth”
MO DIVISION OF YOUTH SERVICES FUNDAMENTAL PRACTICES
Training Attendance Record (Sign-in Sheets)

Interviews:
Random Staff
Youth Facility Manager/PCM

Provisions (a) and (c):
All employees shall be provided information on the agency’s zero tolerance of sexual abuse and sexual harassment of offenders and an overview of staff duties to meet PREA requirements. Documentation of receipt of the information and training shall be maintained in the employee training file.

The agency trains all employees who may have contact with residents in compliance with the standard. All MTVTC employees are trained on the Agency and Facility’s zero-tolerance of sexual abuse and sexual harassment of offenders and an overview of staff duties to meet PREA Standard 115.331 requirements. Documentation of receipt of training is maintained in the employee training file. The facility Policy addresses PREA related training for staff. All interviewed staff members were familiar with the PREA information regarding primary components of preventing, detecting and responding to sexual abuse or sexual harassment. PREA training is provided to staff, as indicated by a review of Policy and training documents. The documents and staff interviews support refresher training is also conducted and is documented.

The MTVTC random staff interviewed and the Youth Facility Manager/PCM reported the training is provided as required. All staff members interviewed, and documentation reviewed by the auditor verified the general topics identified in the Agency PREA Standard identified above, were included in their training. The Policy, training materials, staff interviews, review of the trainings log and acknowledgement statements verify the staff training occurs. Training is conducted annually and refresher training is provided as needed. Staff interviews confirmed they have received training on the 11 required topics.

Provision (b):
Such training shall be tailored to the unique needs and attributes of residents of juvenile facilities and to the gender of the residents at the employee’s facility. The employee shall receive additional training if the employee is reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa.

The facility houses male youth offenders and the training considers the needs of the population as determined by a review of training curricula and interviews with random staff. The Policy state the training shall be tailored to the needs and attributes to the population served.

Provision (d):
The agency shall document, through employee signature or electronic verification that employees understand the training they have received.

The Policy provides all training be documented. Staff members sign training rosters and training acknowledgement statements. A checklist is utilized for orientation training for all new employees and contains the elements of PREA training. The facility provided the Auditor with several examples for verification of the training occurring and the training was verified through staff interviews. The facility follows this provision of the standard.

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is following the provisions of 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.

Documents Reviewed:
Missouri Division of Youth Services (DYS) 9.18 PREA Section I-III (PREA) Training and Education
MO DIVISION OF YOUTH SERVICES FUNDAMENTAL PRACTICES

Interviews:
Youth Facility Manager/PCM
APC

Provision (a):
The agency shall ensure 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.

The Policies require volunteers and contractors who have contact with residents, be trained on PREA and their responsibilities regarding sexual assault prevention, detection, and response to allegations of sexual abuse and sexual harassment. A review of training records and interviews document the training occurs.

Provision (b):
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, but all volunteers and contractors who have contact with residents shall be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

The interviews revealed the PREA training informs the participants of their role in reporting allegations of sexual abuse and sexual harassment. The participants are informed of their responsibilities regarding sexual abuse prevention, detection, and response to a PREA allegation. The training is based on the services provided by the contractors and volunteers. The contractors and volunteers also stated the training includes a review of the zero-tolerance policy regarding sexual abuse and sexual harassment of residents.

Provision (c):
The agency shall maintain documentation confirming that volunteers and contractors understand the training they have received. The Non-Direct Care Staff Volunteer and Contracted Service Provider Agreement contain the information reviewed with the contractor and volunteer. The document also serves as the training acknowledgement statement containing the signature of the participant and the date, confirming their understanding of the PREA information.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with the provisions of this standard regarding volunteer and contractor training.

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 such education? ☒ 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.

Documents Reviewed:
Missouri Division of Youth Services (DYS) 9.18 PREA Section I-III
PREA Education Safety First Lesson Plan (English/Spanish)
DYS Policy 9.5 Res. Care sec IIIB1d
DYS Policy 8.3 sec IIIB

Interviews:
Random Residents
Intake Staff
Youth Facility Manager/PCM

Provisions (a) and (b):
During the intake process, residents shall receive information explaining, in an age appropriate fashion, the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. (b): Within 10 days of intake, the agency shall provide comprehensive age-appropriate education to residents either in person or through video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents.

Facility Policy (DYS) 9.18 PREA Section I-II provides all residents admitted receive information about the facility, including PREA education. According to the YFM/PCM an orientation will be provided on the day when residents are admitted to the facility. Policy provides that residents receive a comprehensive age appropriate PREA education session when youth are admitted to the facility. The results of the staff and resident interviews indicated the information provided to the residents is comprehensive and age appropriate. The intake staff's interview revealed residents are educated regarding their rights to be free from sexual abuse and sexual harassment, and to be free from retaliation for reporting such incidents. The PREA education sessions include a review of the Safety Brochure. The residents sign acknowledgement statements confirming their receipt of the PREA information. A review of documentation showing dates and indicating residents' participation in PREA education sessions confirmed the PREA education sessions occur. The PREA-related information is provided to staff in policies and procedures, training and staff meetings.

Provision (c):
Current residents who have not received education prior to arrival at the facility shall be educated within one year of the effective date of the PREA standards, and shall 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.

The Intake staff was interviewed regarding PREA education for residents transferred to WMPC. Available documentation reviewed indicated that residents' receipt of the information, including the resident signing the acknowledgement form.

Provision (d):
The agency shall provide resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills.

The facility has the capability to provide the PREA education in formats accessible to all residents including those who may be hearing impaired; deaf; have intellectual, psychiatric and speech disabilities; low vision; blind; limited reading, limited English proficient, and based on the individual need of the resident. Posted PREA information is in English and Spanish accessible to residents. Staff, contractors, volunteers, and visitors are aware of services available to assist with disabled residents. Staff interviews confirmed residents are not used as translators or readers for other residents.

Provision (e):
The agency shall maintain documentation of resident participation in these education sessions.

A sample of signed acknowledgement statements were reviewed which supported the residents' involvement in PREA education sessions. The resident interviewed was aware of PREA information, including the rights regarding PREA, how to report allegations and that they would not be punished for reporting allegations of sexual abuse or sexual harassment. The PREA Compliance Manager was interviewed regarding PREA education for residents. The PREA Compliance Manager ensures residents' receipt of the information, including the resident signing the acknowledgement form.

Provision (f):
In addition to providing such education, the agency shall ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats.

A manual, PREA Education Safety First Lesson Plan (English/Spanish), is provided to each resident to eliminate incidents of sexual abuse and sexual harassment. The brochure provides educational information regarding sexual abuse and victims. The residents revealed they can report allegations of sexual abuse or sexual harassment by telling a staff member; telling a family member who may report the allegation for them; access to the hotline to report allegations of sexual abuse or sexual harassment; or complete a grievance form. Each resident is provided a Handbook and Safety Brochure. Posters were observed placed throughout the facility and were easy to see and read.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with the provision of this standard.

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.

Documents Reviewed:
Missouri Division of Youth Services (DYS) 9.18 PREA Section I-III (PREA) 2.17

Missouri Children's Division Out-of-Home Investigation Unit (CD-OHI) Protocols
Division of Legal Services (DLS)

Interviews:
Youth Facility Manager/PCM
Assistant Regional Administrator

Provision (a):
In addition to the general training provided to all employees pursuant to §115.331, the agency shall ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings.

The initial review of the Missouri Division of Youth Services (DYS) Policy 9.18 (Prison Rape Elimination Act of 2003) requires an administrative and/or criminal investigation for all allegations of sexual abuse or sexual harassment and requires staff to refer all alleged incidents of sexual abuse, harassment or misconduct to the Missouri Children's Division Out-of-Home Investigation Unit (CD-OHI) for residents under the age of 18 and Division of Legal Services (DLS) for residents over 18 years of age. Interviews with the Assistant Regional Administrator and the Youth Facility Manager it was stated that MTVTC staff do not conduct administrative or criminal investigations; therefore, their staff have not received training in conducting such investigations in confinement settings.

Provision (b):
Specialized training shall include: Techniques for interviewing juvenile sexual abuse victims; Proper use of Miranda and Garrity warnings; Sexual abuse evidence collection in confinement settings and the criteria and evidence required to substantiate a case for administrative action or prosecution referral

The Youth Facility Manager/PCM stated that the Children's Division investigators and Division of Legal Services (DLS) investigators training is compliant with the PREA Standard requirements identified in provision (b).

Provision (c):
The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations.

The Youth Facility Manager stated that MTVTC staff does not conduct administrative or criminal investigations; therefore, their staff does not receive training in conducting such investigations in confinement settings. However, that documentation is available at the Agency to verify that all the agency designated investigators for CD-OHI and DLS have completed the required training in conducting sexual abuse investigations. MODYS does not have an agency designated administrative staff to conduct sexual abuse investigations, they can investigate harassment. Allegations for youth under age 18 are referred to Children's Division, Out of Home Investigation, for allegations regarding youth age 18 and over are referred to Division of Legal Services Investigation Unit.

Provision (d):
Auditor is not required to audit this provision.

Conclusion:
Based upon the review and analysis of the available documentation, the Auditor has determined the facility is compliant with the provision of 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? ☒ Yes ☐ No

- 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? ☒ Yes ☐ No

- 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? ☒ Yes ☐ No

- 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? ☒ Yes ☐ No

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.) ☐ 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? ☒ Yes ☐ No

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? ☒ Yes ☐ No

- Do medical and mental health care practitioners contracted by and volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? ☒ 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.

Documents Reviewed:
Missouri Division of Youth Services (DYS) 9.18 PREA Section I-III (PREA)
DYS Policy 9.18 PREA Section IIIC (a)
DYS Policy 3.18 Training Section IIIJ
Medical Staff Training Records
Pre-Audit Questionnaire (PAQ)

Interviews:
Youth Facility Manager/PCM
Medical Services Providers

Provision (a):
The agency shall 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.

MTVTC utilizes contract mental health and medical care practitioners to assist with mental health and medical needs. The YFM/PCM stated that all extended or emergency services would be referred to appropriate practitioners in the community. Interviews with contracted mental health staff confirmed additional specialized training. All medical and mental health care practitioners who work regularly in MTVTC have received PREA training to include in how to detect and assess signs of sexual abuse and sexual harassment, how to preserve physical evidence of sexual abuse, how to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment and how and to whom to report allegations or suspicions of sexual abuse and sexual harassment.

Provision (b):
If medical staff employed by the agency conduct forensic examinations, do such medical staff receive appropriate training to conduct such examinations?

N/A. Medical staff at the facility does not conduct forensic exams.

Provision (c):
The agency shall maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere

It was evident through the medical and mental health staff interviews they had received the basic PREA training provided to all staff and the specialized on-line training offered by NIC. A review of the training documentation confirmed medical and mental health staff receives the required refresher PREA training on an annual basis. Additionally, the medical and mental health staff is required to review and sign the DYS Fundamental Practices form to acknowledge they received the training and understand their responsibilities in the event of an incident. The medical staff does not conduct forensic examinations.

Provision (d):

Medical and mental health care practitioners employed by the agency shall also receive training mandated for employees by §115.331 and §115.332.

Documentation indicated that contracted mental health and medical staff have received the agency mandated training. It was evident through the medical and mental health staff interviews they had received the basic PREA training provided to all staff.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with the provision of this standard. DYS Policies address training requirements for mental health and medical contracted and volunteers with documented orientation and education.

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: Prior sexual victimization or abusiveness? ☒ Yes ☐ No

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

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

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

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

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

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

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

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

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: 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.

Documents Reviewed:
DYS Policy 9.5 Res. Care Section IIIA-B and IIIB1a
DYS Policy 9.18 PREA Section IIID1b & IIID2e
DYS Policy 6.7 Section I
PREA VULNERABILITY INFORMATION REVIEW (PVIR) SCREENING RESULTS AND FOLLOW-UP NOTIFICATION FORM
Facility Health Screening Form DYS F7-17

Interviews:
PREA Coordinator
Staff Responsible for Risk Screening
Medical Provider Contractor
Mental Health Contractor

Provision (a):
Within 72 hours of the resident's arrival at the facility and periodically throughout a resident's confinement, the agency shall obtain and use information about each resident's personal history and behavior to reduce the risk of sexual abuse by or upon a resident. The Policy provides a risk screening occurs within 72 hours upon arrival to the facility. All intake staff will interview the resident and obtain information about the resident's personal history and behavior in order to reduce the risk of sexual abuse by or upon a resident. The resident's risk level is reassessed periodically.

Missouri Division of Youth Services (DYS) 9.18 PREA Section I-III (PREA) The agency has a policy that requires screening for risk of sexual abuse victimization or sexual abusiveness toward other residents. Policy requires that residents be screened within 72 hours of intake and requires that the resident's risk level be reassessed periodically throughout their confinement. If the result from the Risk Assessment Tool indicates a probability for victimization or sexually aggressive behavior and/or violent behavior, the youth shall be assigned to an appropriate room close to staff posts. If the screening indicates that a youth has experienced prior victimization or has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, the intake staff shall offer the youth a follow-up meeting with a Mental Health specialist. The follow-up shall be completed within 14 days. The Intake staff also completes an inspection of any other medical and mental health screenings that may have been conducted, as well as conversations with the youth during the admission process. Existing court records and case files are also consulted, if available.

Provision (b):
Such assessments shall be conducted using an objective screening instrument.

The PREA Vulnerability Information Review (PVIR) and the Facility Health Screening Form is used to obtain information required by the standard.

Provision (c):
At a minimum, the agency shall attempt to ascertain information about:
(1) Prior sexual victimization or abusiveness;
(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;

(3) Current charges and offense history;
(4) Age;
(5) Level of emotional and cognitive development;
(6) Physical size and stature;
(7) Mental illness or mental disabilities;
(8) Intellectual or developmental disabilities;
(9) Physical disabilities;
(10) The resident's own perception of vulnerability; and
(11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents.

The Auditor reviewed the PREA Vulnerability Information Review (PVIR) screening instrument and determined all factors required by this provision of the standard are included. The interview with the PREA Compliance Manager confirmed she is aware of the elements of the risk screening instrument. The resident interviews also confirmed the administration of the screening instrument. The facility provided the Auditor with examples of the screening tool. The PVIR is used to obtain information required by the standard, including but not limited to prior sexual victimization or abusiveness; self-identification; current charges and offense history; intellectual or developmental disabilities; and a resident's concern regarding his own safety. The interview and review of Policy revealed how the objective instrument is administered to glean information to assist staff in keeping residents safe. The responses on the instrument garner a score and the risk level is determined by definition and the corresponding number to that definition. The Policy states residents will be screened within 72 hours of admission; however, interviews with residents indicated it is also administered earlier.

Provision (d):
This information shall be ascertained through conversations with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files.

All residents are screened within twenty-four hours upon arrival at the facility to determine placement and their special needs. Those residents who score vulnerable to victim or sexually aggressive are included into their alert system, as well as receiving further assessments, as identified. DYS PREA Vulnerability Information Review (PVIR) form, medical and mental health assessment and various other forms (Assessment Summary) are used in combination with information about personal history, medical and mental health screenings, conversations, classification assessments as well as reviewed court records and case files. The review of the instrument and interview with the PREA Compliance Manager and a review of relevant documentation of risk screening confirmed the information is ascertained through conversations with the residents.

Provision (e):
The agency shall implement 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.

DYS PREA Vulnerability Information Review (PVIR) form, medical and mental health assessment and various other forms (Assessment Summary) are used in combination with information about personal history, medical and mental health screenings, conversations, classification assessments as well as reviewed court records and case files. Residents are reassessed within six (6) months of their arrival and throughout their stay at the facility. The facility's policies limit staff access to this information on a "need to know basis".

Conclusion:

Based upon the review and analysis of the available evidence, the Auditor has determined the facility is fully compliant with this standard regarding screening for risk of victimization and abusiveness.

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: Program 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? ☒ Yes ☐ No

- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? ☒ Yes ☐ No

- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? ☒ Yes ☐ No

- Do residents in isolation receive daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- Do residents also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.342 (c)

- Does the agency always refrain from placing: Lesbian, gay, and bisexual 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 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 program 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 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 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 paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?) ☒ Yes ☐ No ☐ NA

- If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?) ☒ 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? ☒ 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.

Documents Reviewed:
DYS Policy 9.18 PREA Section IIID2e
DYS Policy 6.1 Section IIID
DYS Policy 9.28 IIIC
DYS Policy 9.8 IIB4
PREA VULNERABILITY INFORMATION REVIEW (PVIR) SCREENING RESULTS AND FOLLOW-UP NOTIFICATION FORM
Facility Health Screening Form DYS F7-17
Pre-Audit Questionnaire

Interviews:
Youth Facility Manager/PCM
Staff Responsible for Risk Screening/Intake
Random Staff
Random Residents

Provision (a):
The agency shall use all information obtained pursuant to § 115.341 and subsequently to make housing, bed, program, education, and work assignments for residents with the goal of keeping all residents safe and free from sexual abuse.

The facility Policy provides guidance to staff regarding the use of the information obtained from the screening forms. The Youth Facility Manager II and assigned staff utilize various forms, DYS PREA

Vulnerability Information Review (PVIR), the Assessment Summary to name a few and any other pertinent information during the resident's admission process. Also, the staff determine placement of residents in a specific sleeping assignment according to their risk level (low, medium or high). Staff interviews described how information is derived from the various forms and the initial medical and mental health/substance abuse screening forms to determine placement and risk level. In addition, the policy describes the screening and assessment process and how that information, along with information derived from medical and mental health screening and assessments, records reviews, database checks, conversations and observations, is used to determine a resident's appropriate placement, housing and bed assignments, as well as work, education, and program assignments with the goal of keeping all residents safe and free from sexual abuse.

Provision (b):
Residents may be 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. During any period of isolation, agencies shall not deny residents daily large-muscle exercise and any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible.

The Facility Youth Manager stated during the interview that residents are not placed in isolation or on a high risk status as a means of keeping them safe from discrimination, harassment, violence or abuse. Staff is expected to immediately intervene and address any behaviors that threaten the safety of another resident. Residents may be placed on no-contact separation from other residents for situation that may include if they were involved in the same crime for which they are being held; if they pose a serious or credible threat to another resident; if another resident poses a serious or credible threat to them; or if a resident makes this request due to prior conflict with another resident. The ARA stated that during any period of isolation, agencies shall not deny residents shall participate in regular programming after orientation based on the information obtained with the goal of keeping the residents safe, including from sexual abuse/assault and harassment.

Provision (c):
Lesbian, gay, bisexual, transgender, or intersex residents shall not be placed in particular housing, bed, or other assignments solely on the basis of such identification or status, nor shall agencies consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

The initial review of the Missouri Division of Youth Services (DYS) Policy 9.18 (Prison Rape Elimination Act of 2003); Policy 9.08 (Separation); Policy 9.28 (Developing Relationships) and Policy 6.01 (Programmatic Rights of Youth & Grievance Process) prohibits gay, bi-sexual, transgender and intersex residents being placed in a dorm area, bed or other assignments based solely on their identification or status. In addition, the policy describes the screening and assessment process and how that information, along with information derived from medical and mental health screening and assessments, records reviews, database checks, conversations and observations, is used to determine a resident's appropriate placement, housing and bed assignments, as well as work, education, and program assignments with the goal of keeping all residents safe and free from sexual abuse. During the comprehensive site review, there were no rooms observed to be reserved for transgender or intersex residents. The restroom/showers were observed and were configured for a reasonable amount of privacy.

Provision (d):
In deciding whether to assign a transgender or intersex resident to a facility for male or female residents, and in making other housing and programming assignments, the agency shall consider on a

case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems.

The Policy also provides that housing and program assignments for transgender or intersex residents would be made on a case-by-case basis and these residents would not be placed in particular or special housing which was evident from staff interviews. There were no transgender or intersex residents in the facility during the site visit and this audit period. The PCM's interview indicated that the facility would consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems.

Provision (e):
Placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident.

The Policy states placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year. The PCM confirmed each transgender or intersex resident would be reassessed at least twice each year to review any threats to safety experienced by the resident. This function would be done to review any threats to safety experienced by the resident.

Provision (f):
Transgender and intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments.

The FYM stated that transgender and intersex resident's own views, with respect to his or her own safety, is given serious consideration when making facility and housing placement decisions and programming assignments.

Provision (g):
Transgender and intersex residents shall be given the opportunity to shower separately from other residents.

The Policy states transgender or intersex residents shall be given the opportunity to shower separately from other residents which is also supported by staff interviews. Staff and resident interviews indicated that staff explained to each resident during intake, the shower procedures.

Provision (h):
If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety and the reason why no alternative means of separation can be arranged?

Policy indicates that residents will not be placed in isolation or on a high risk status as a means of keeping them safe from discrimination, harassment, violence or abuse. Staff are expected to immediately intervene and address any behaviors that threaten the safety of another resident. All incidents of isolation are documented.

Provision (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?

The FYM stated that residents may be placed on no-contact separation from other residents for situation if they pose a serious or credible threat to another resident or if another resident poses a serious or credible threat to them. The facility would afford a review to determine whether there is a

continuing need for separation from the general population EVERY 30 DAYS. There were no residents held in isolated status over 30 days during the past 12 months. If so, the agency would follow the requirements of this standard.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is fully compliant with this standard regarding use of screening information. The facility uses information from the risk screening required by §115.341 with the goal of keeping all residents safe and free from sexual abuse.

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? ☒ Yes ☐ No

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.

Documents Reviewed:
DYS Policy 9.18 (Prison Rape Elimination Act of 2003)
Policy 6.1 (Programmatic Rights of Youth & Grievance Process)
Policy 3.8 (Employee Conduct)
Department of Social Services (DSS) Policy 2-101 (Sexual Harassment /Inappropriate Conduct)
Missouri Revised Statute Chapter 210 Child Protection and Reformation Section 210.115.1 (Mandated Reporter Law)
MO DIVISION OF YOUTH SERVICES FUNDAMENTAL PRACTICES MANUAL

Interviews:
Youth Facility Manager/PCM
Random Staff
Random Residents

Provision (a):
The agency shall provide multiple internal ways for residents to privately report sexual abuse and 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.

DYS Policy 9.18 (Prison Rape Elimination Act of 2003); Policy 6.01 (Programmatic Rights of Youth & Grievance Process); Policy 3.08 (Employee Conduct); Department of Social Services (DSS) Policy 2-101 (Sexual Harassment/Inappropriate Conduct) and the Missouri Revised Statute Chapter 210 Child Protection and Reformation Section 210.115.1 (Mandated Reporter Law) provides multiple internal ways for staff and residents to report privately sexual abuse and harassment retaliation, staff neglect or violation of responsibilities that may have contributed to such incidents.

Provision (b):
The agency shall also provide at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. Residents detained solely for civil immigration purposes shall be provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security.

These various ways of reporting include advising an administrator, a staff member, telephoning the hotline number, placing a written complaint in the grievance box and third party. Residents may request the use of the telephone from staff or designated telephones located in the corridors. When using the telephones in staff areas, staff is required to dial all calls. However, when calls are made to the Hotline, the residents are allowed privacy to report an allegation of abuse and/or request advocacy services.

It was reported to the Assistant Regional Administrator and the Facility Youth Manager/FPCM that resident interviews indicated several ways to report sexual abuse and sexual harassment by telephoning the hotline, speak with a staff they trust or third party. However, most residents identified the grievance box as a means to report sexual abuse and sexual harassment.

While touring the entire facility, there were postings of the PREA information (bulletin boards) with reporting information and a locked grievance box with grievance forms located throughout the group home. MTVTC staff revealed staff could use the emergency phone to report allegations of abuse. A review of documentation revealed that there were no allegations of sexual abuse reported during this audit period.

Provision (c):
Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports.

The agency has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing anonymously and from third parties. MTVTC requires all staff to report immediately, in accordance with DYS PREA Policy guidelines, any knowledge, suspicion, or information regarding an incident of offender sexual abuse or offender sexual harassment. The staff interviews confirmed the methods available to residents for reporting allegations of sexual abuse and sexual harassment. Staff members are required to accept third-party reports and to document verbal reports. The resident interviews demonstrated their familiarity with the various ways they may report either in person, in writing, by phone, completing a grievance or Medical Request Form, or through a third-party.

Provision (d):
The agency shall provide a method for staff to privately report sexual abuse and sexual harassment of residents.

The staff interviews revealed staff can privately report allegations of sexual abuse. The interviews collectively identified the following ways a report can be made privately: use of the telephone on the living units; use of telephone in an office; third-party reporting form online; report by email to administrative staff; and/or talk to supervisor in private.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding resident reporting.

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 ☒ NA

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 allegation 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.

Documents Reviewed:
Missouri Division of Youth Services (DYS) 9.18 PREA Section I-III (PREA)
Grievance Forms
Safety Pamphlet

Interviews:
Random Staff
Youth Facility Manager/PCM
Random Residents

Provision (a):
An agency shall be exempt from this standard if it does not have administrative procedures to address resident grievances regarding sexual abuse.

The agency is exempt because it does not have administrative procedures to address resident grievances regarding sexual abuse or harassment. Missouri Division of Youth Services (MDYS) Policy 9.18 (Prison Rape Elimination Act of 2003) describes the orientation residents receive explaining how to use the grievance process. However, residents may place a written grievance or complaint in the locked grievance box located in areas accessible to the residents. All grievances shall be handled expeditiously and without threats of or reprisals against the juvenile.

Provision (b):
(1) The agency shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse.
(2) The agency may apply otherwise-applicable time limits on any portion of a grievance that does not allege an incident of sexual abuse.
(3) The agency shall not require a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse.
(4) Nothing in this section shall restrict the agency's ability to defend against a lawsuit filed by a resident claiming the applicable statute of limitations has expired.

MDYS does not have administrative procedures for dealing with resident's grievances regarding sexual abuse or harassment. The policies and procedures describe an unimpeded process. Residents are not required to utilize a formal process for reporting allegations of sexual abuse or sexual harassment nor are they required to submit it to the staff member involved in the allegation.

Provision (c):
The agency shall ensure that—
(1) A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint, and
(2) Such grievance is not referred to a staff member who is the subject of the complaint.

Most resident interviews and documentation confirmed there is a grievance process and a written complaint can be placed in the locked grievance box. Residents indicated they would contact a trusted staff or telephone the hotline in relation to sexual abuse or sexual harassment complaints. According to formal and informal staff and resident interviews, residents are not required to give a grievance to a staff member who is the subject of the complaint. Staff members are not permitted to place a grievance in the box for the resident. A locked grievance box is available in designated areas.

Provision (d):
(1) The agency shall 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.
(2) Computation of the 90-day time period shall not include time consumed by residents in preparing any administrative appeal.
(3) The agency may claim an extension of time to respond, of up to 70 days, if the normal time period for response is insufficient to make an appropriate decision. The agency shall notify the resident in writing of any such extension and provide a date by which a decision will be made.
(4) 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, the resident may consider the absence of a response to be a denial at that level.

The agency is exempt because it does not have administrative procedures to address resident grievances regarding sexual abuse or harassment.

Provision (e):
(1) Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, shall be permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of residents.
(2) 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.
(3) If the resident declines to have the request processed on his or her behalf, the agency shall document the resident's decision.

(4) A parent or legal guardian of a juvenile shall be allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile. Such a grievance shall not be conditioned upon the juvenile agreeing to have the request filed on his or her behalf.

Resident interviews indicated several ways to report sexual abuse and sexual harassment by telephoning the hotline, speak with a staff they trust or third party. Most residents identified the grievance box to report sexual abuse and sexual harassment. Most resident and staff interviews, along with the resident's handbook, postings, and supporting documentation verified compliance with this standard. The agency is exempt because it does not have administrative procedures to address resident grievances regarding sexual abuse or harassment.

Provision (f):
(1) The agency shall establish procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse.
(2) After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, the agency shall 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, shall provide an initial response within 48 hours, and shall issue a final agency decision within five calendar days. The initial response and final agency decision shall document the agency's determination whether the resident is in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance.

The agency is exempt because it does not have administrative procedures to address resident grievances regarding sexual abuse or harassment. Once a grievance is received, it is dealt with through the appropriate administrative channels and Policy.

Provision (g):
The agency may discipline a resident for filing a grievance related to alleged sexual abuse only where the agency demonstrates that the resident filed the grievance in bad faith.

The FYM stated that the agency does not have a formal discipline procedure for residents for filing a grievance related to alleged sexual abuse if the resident filed the grievance in bad faith. The agency is exempt because it does not have administrative procedures to address resident grievances regarding sexual abuse or harassment.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding exhaustion of administrative remedies.

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 assessable 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? ☒ Yes ☐ No

- 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.

Documents Reviewed:

DYS Policy 9.18 PREA Sec. IIIE3a
DYS Policy 6.2 Legal Representation
DYS Policy 9.18 PREA Sec. IIIE3d
DYS Policy 6.5 Youth's Visit, Mail and Telephone
DYS Policy 9.18 Sec. IIIE3d
Memorandum of Agreement between the Missouri Department of Social Services Division of Youth Services and the Victim Center

Interviews:
Youth Facility Manager/PCM
Advocacy Services Representatives

Provision (a):
The facility shall 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, and, for persons detained solely for civil immigration purposes, immigrant services agencies. The facility shall enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible.

The initial review of the Missouri Division of Youth Services (DYS) Policy 9.18 (Prison Rape Elimination Act of 2003) ensures that residents are provided access to outside confidential support services, legal counsel and parent/guardian. Victim Center has agreed to provide services to include emotional support related to sexual abuse. Mercy Hospital (SAFE certified) provides the emergency and forensic medical examinations at no financial cost to the victim. Posters containing crisis hot-line number are prominently posted in the hallways and lobby area. Staff and youth interviews confirmed that staff provide youth with the limitations of confidentiality regarding mandatory reporting laws. Youth interviews confirmed that those who currently have attorneys can communicate with them confidentially. None reported being denied access to their attorneys. All youth reported that they have family visitation and that they have never been denied access to their families. All youth can make phone calls weekly to family members.

Provision (b):
The facility shall 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.

The Policy addresses confidentiality of the advocacy support services. The resident receives information regarding the limitations of confidentiality during the intake process. An acknowledgement brochure specific to the review of the reporting and advocacy services contains information regarding the advocacy services to be provided by the Preferred Family Healthcare/Bridgeway Behavioral Health.

Provision (c):
The agency shall 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. The agency shall maintain copies of agreements or documentation showing attempts to enter into such agreements.

Documentation reviewed indicated that the facility has made attempts with the Victim Center to enter into a memorandum of understanding to provide residents with confidential emotional support services related to sexual abuse. Although the Victim Center has agreed to provide some services, they would not sign a MOU.

Provision (d):
The facility shall provide residents with reasonable and confidential access to their attorneys or other legal representation?

Resident interviews confirmed they have reasonable and confidential access to their attorneys and reasonable access to their parent/guardian either through visitation, correspondence or by telephone. The facility provides the residents' access to weekly calls to parents/legal guardians, free hotline telephone calls to report sexual abuse. During normal circumstances, permits parental/legal guardians' visitation, and materials to write letter to parents/ legal guardians.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding resident access to outside confidential support services and legal representation.

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.

Documents Reviewed:
Missouri Division of Youth Services (DYS) 9.18 PREA Section I-III
PREA Brochure (Safety Pamphlet)
Posted Information
DYS web link

Interviews:
Random Staff
PCM
Random Resident

Provision (a):
The agency shall establish a method to receive third-party reports of sexual abuse and sexual harassment and shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident.

The Policy addresses third-party reporting and interviews revealed random residents and staff members are aware third-party reporting of sexual abuse and sexual harassment requirements. The agency's web link establishes a method to receive third-party reports of sexual abuse and sexual harassment and distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor determined the facility is complying with third-party reporting. The facility provides various methods for third-party reports of sexual abuse or sexual harassment.

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 the 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? (N/A if the alleged victim is not under the guardianship of the child welfare system.) ☒ Yes ☐ No ☐ NA

- 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.

Documents Reviewed:
DYS Policy 9.18 PREA Section IIIF2
DYS Policy 3.8 Employee Conduct Sec. IIIC & IIIC2

Interviews:
Random Staff
Medical Staff
Mental Health Staff
Youth Facility Manager/PCM
Random Residents

Provision (a) and (b):
The agency shall require 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; 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 or retaliation. (b): The agency shall also require all staff to comply with any applicable mandatory child abuse reporting laws.

The DYS Policy 3.8 Employee Conduct Sec. IIIC2 and DYS Policy 9.18 PREA Section IIIF2 collectively address provisions of the standard. 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. In addition, the agency requires all staff to comply with applicable mandatory child abuse reporting laws. All staff receives information on clear steps on how to report sexual misconduct and to maintain confidentiality through the facility protocol and/or training. The staff would complete an incident report with the details of any incidents that would occur in the facility in compliance with this standard. Additionally, interviews with medical and mental health staff confirmed their responsibility to inform residents under 18 years old of their duty to report and limitations of confidentiality.

Provision (c):
Apart from reporting to designated supervisors or officials and designated State or local services agencies, staff shall be 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.

Facility Policy supports that after allegations have been appropriately reported, staff will not be permitted to give out any other information relating to what was reported except when necessary to obtain treatment for the resident, aid in the investigation, or help retain the security of the facility. Staff is expected to continue to abide by the confidentiality requirements of the facility. Interviews with staff indicated their knowledge of the prohibition of 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. Based on the review of documentation and interviews with staff, it is evident the facility follows this provision of the standard.

Provision (d):

(1) Medical and mental health practitioners shall be 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. (2) Such practitioners shall be required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality.

The medical health staff interviewed stated residents are informed at the initiation of services of the limitations of confidentiality and the duty of the staff members to report. The clinical staff interviewed revealed they are mandated reporters.

Provision (e):
The facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators.

The Youth Facility Manager (YFM) stated that MTVTC staff does not conduct administrative or criminal investigations; therefore, upon receipt of any allegation of sexual abuse, the YFM/PCM will report the allegation to the appropriately identified investigative agency. The Assistant Regional Administrator stated that the YFM/PCM shall also contact the resident's parents, attorney, and/or legal guardians within three working days of receipt of the information. Missouri Children's Division Out-of-Home Investigation Unit (CD-OHI) conducts the administrative investigations of sexual abuse and sexual harassment allegations for residents under the age of 18 and has in place a policy governing the conduct of such investigations.

Provision (f):
The facility shall report all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the facility's designated investigators.

Upon receipt of any allegation of sexual abuse, the Youth Facility Manager (YFM) stated that he is required to report the allegation to the appropriately identified investigative agency.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor determined the facility is complying regarding agency and staff reporting duties. The interviews with random staff, mental health and medical staff and YFM/PCM revealed their awareness of the requirements regarding the reporting duties.

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.

Document Reviewed:
DYS Policy 9.18 PREA Section IIIF3
Pre-Questionnaire Documentation

Interviews:
Youth Facility Manager/PCM
Random Staff

Provision (a) §115.362
When an agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the resident.

Facility Policy requires staff to protect the residents through implementing protective measures. Administration DYS PREA Vulnerability Information Review (PVIR) form provides information that assists and guide staff in keeping residents safe through housing and program assignments. The interviews of the random staff and the Youth Facility Manager/PCM revealed protective measures include but are not limited to immediately alerting supervisors and management staff and separating the residents including moving to a different housing unit.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard and the provisions regarding agency protection duties.

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.

Documents Reviewed:
DYS Policy 9.18 PREA section IIIF5
DYS Policy 3.8 Employee Conduct Sec. IIIC2
DYS Policy 3.8 Employee Conduct Section IIIC

Interviews:
Youth Facility Manager/PCM
Supervisory Staff

Provisions (a), (b), (c), and (d):
Upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred and shall also notify the appropriate investigative agency. (b) Such notification shall be provided as soon as possible, but no later than 72 hours after receiving the allegation. (c) The agency shall document that it has provided such notification. (d) The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards.

The agency has a policy requiring 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. The agency's policy also requires that the head of the facility notify the appropriate investigative agency and the child abuse/neglect hotline within 72 hours. In addition, the agency or facility policy requires that allegations received from other agencies or facilities are investigated in accordance with the PREA standards.

Conclusion:
Based upon the information received and interviews, the Auditor has determined the facility is compliant with this standard regarding reporting to other confinement facilities.

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.

Documents Reviewed:
Missouri Division of Youth Services (DYS) 9.18 PREA Section I-III
Division of Youth Services First Responder Protocols for Sexual Abuse

Interviews:
Youth Facility Manager/PCM
Random Staff
Non-Security Staff First Responder

Provision (a):
Upon learning of an allegation that a resident was sexually abused, the first staff member to respond to the report shall be required to:
(1) Separate the alleged victim and abuser;
(2) Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;
(3) If the abuse occurred within a time-period that still allows for the collection of physical evidence, 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; and
(4) If the abuse occurred within a time-period that still allows for the collection of physical evidence, 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.

DYS Policy (DYS) Policy 9.18 and DYS First Responder Protocols for Sexual Abuse provides that upon learning of an allegation that a resident was sexually abused, the first security-level staff member to respond to the report shall be required to separate the alleged victim and abuser; preserve and protect any crime scene until appropriate steps can be taken to collect any evidence; if the abuse occurred within a time-period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence. The interviews with staff confirmed awareness of first responder duties and the training they had been provided. There were no allegations that a resident was sexually abused in the last 12 months.

Provision (b):
If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff.

The Auditor interviewed non-security staff who may act as a first responder and they were familiar with the duties in that role. All responders indicated they would alert the supervisor, separate the victim and perpetrator, and request the victim and perpetrator do not take any actions that could destroy physical evidence.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding staff first responder duties.

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.

Documents Reviewed:
Missouri Division of Youth Services (DYS) 9.18 PREA Section I-III (PREA)
DYS Coordinated Response to Report of Sexual Abuse

Interviews:
Youth Facility Manager/PCM
Random Staff

Provision (a): §115.365
The facility shall develop a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership.

The review of the Missouri Division of Youth Services (DYS) Policy 9.18 (Prison Rape Elimination Act of 2003) and DYS Coordinated Response to Reports of Sexual Abuse provides a written coordinated response system to coordinate actions taken in response to an incident of sexual assault among staff first responders, administration, executive staff and contract medical and mental health professionals. MTVTCs staff has a system in place providing the staff with clear actions to be taken by each discipline for accessing, contacting administrative staff, medical and mental health staff, contacting CD-OHI or DLS and law enforcement, victim advocate services, & parent/guardian and a number of other individuals. Interviews with the Youth Facility Manager and other staff validated their technical knowledgeable of their duties in response to a sexual assault.

Random staff interviewed was familiar with their roles regarding the response to an allegation of sexual abuse. The YFM/PCM discussed the coordinated actions in response to an incident of sexual abuse which was parallel to Policy and the flow chart. Staff members are directed to follow the steps outlined and to utilize the Checklist in addressing the situation.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility complies with the provisions of the standard regarding a coordinated response to an incident of sexual abuse. No allegations of sexual abuse have been reported during this audit period.

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.

Documents Reviewed:
Missouri Division of Youth Services (DYS) 9.18 PREA Section I-III (PREA)
Labor Agreement Between the State of Missouri Department of Social Services and Health & Senior Services (Division of Regulation and Licensure-Sections for Long term Care and Child Care

Regulations) and Division of Facilities Management, Design and Construction AND Communication Workers of America (CWA) Local 6355, AFL-CIO, Article 13

Interviews:
Youth Facility Manager/PCM
APC
Random Staff

Provision (a):
The agency and any other governmental entities responsible for collective bargaining on the agency's behalf are 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

There is no agreement that prohibits the DYS from removing alleged staff sexual abusers from contact with any resident pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted, Article -13. Documentation was provided for a labor agreement between the State of Missouri Department of Social Services, Health & Senior Services, Office of Administration and the Communications Workers of America (CWA) Local 6355, AFL-CIO dated 1/1/2016 to 12/31/18 that is consistent with provisions of PREA standards 115.372 and 115.376.

Provision (b):
Auditor is not required to audit this provision.

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 for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, 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? ☒ 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 program 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.

Documentation Reviewed:
DYS Policy 9.18 PREA Section IIIF6
DSS Policy 2-101 Sexual Harassment/Inappropriate Conduct pg.1

Interviews:
Retaliation Monitor
Youth Facility Manager/PCM
Random Staff

Provision (a):
The agency shall establish 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 and shall designate which staff members or departments are charged with monitoring retaliation.

The agency 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. The FYM/PCM stated that staff is responsible for monitoring and reporting each other and other residents for the possibility of retaliation against youth or staff for filing a formal grievance or cooperating with the administrative or criminal investigation. The YFM/PCM is responsible for monitoring retaliation.

Provision (b):
The agency shall 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.

Staff interviews confirmed the facility would protect residents and staff from retaliation for sexual abuse and sexual harassment allegations. Protective measures would include housing changes, transfers, removing alleged abusers, and emotional support services. The YFM/PCM identified protective measures that are aligned with the Policy and standard, including separating the alleged abuser from the alleged victim. The YFM/PCM was knowledgeable on what to look for and what to do with respect to retaliation against, or by, youth and/or staff. This includes periodic status checks. There were no instances of actual or threatened retaliation during the previous 12 months.

Provision (c):

For at least 90 days following a report of sexual abuse, the agency shall monitor the conduct or treatment of residents or staff who reported the sexual abuse and 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, and shall act promptly to remedy any such retaliation. Items the agency should monitor include any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The agency shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need.

The Policy requires the monitoring of items identified in this provision of the standard. YFM/PCM explained during the interview how she would discharge those duties, including monitoring the items identified in the standard and whether a resident filed a grievance alleging sexual abuse or sexual harassment. Retaliation monitoring would occur for 90 days to see if there are any changes that may suggest possible retaliation by residents or staff, and shall act promptly to remedy any such retaliation, according to Policy. The monitoring will continue beyond 90 days, if the initial monitoring indicates a continuing need. There have been no incidents of retaliation during the 12 months preceding the audit.

Provision (d):
In the case of residents, such monitoring shall also include periodic status checks.

The YFM/PCM indicated status checks would be initiated with staff and residents. The Policy states periodic status checks will occur. Managers are required to ensure that actions taken during monitoring are documented in a memo form.

Provision (e):
If any other individual who cooperates with an investigation expresses a fear of retaliation, the facility shall take appropriate measures to protect that individual against retaliation.

The Policy states if any other individual who cooperates with an investigation expresses the occurrence retaliation from another resident or staff member, MTVTC shall take appropriate measures to protect that individual against retaliation.

Provision (f):
Auditor is not required to audit this provision.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding agency protection against retaliation.

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.

Documentation Reviewed:
DYS policy 9.18 PREA Section IIID2d
DYS Policy 9.8 Separation Section IIIB6

Interviews:
Retaliation Monitor
Youth Facility Manager/PCM

Provision (a):
All use of segregated housing is to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342?

The MTVTC does not use segregated housing. The facility has a policy that residents who allege to have suffered sexual abuse may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe and only until alternative means of keeping all residents safe can be arranged. If a resident who alleges to have suffered sexual abuse is held in isolation, the facility affords each such resident a review every 30 days to determine whether there is continuing need for separation from the general population.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding agency protection against retaliation.

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 entity 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.

Documents Reviewed:

DYS Policy 9.18 PREA Section IIIG1Procedures, Investigations
Children's Division (CD) Out of Home Investigation (OHI) Division Protocols
Out of Home Investigation (OHI) Division Investigative/Assessment Summary

Interviews:
Youth Facility Manager/PCM
Assistant Regional Administrator
Random Staff

Provision (a):
When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports.

The agency has a policy related to criminal and administrative agency investigations. The DYS Policy 9.18 PREA Section IIIG1 Procedures, Investigations Policy states that Agency's appointing authority, usually the YFM/PCM, shall ensure cooperation and coordination with all investigating agencies/persons, and that the facility shall share all pertinent documentation, records, and available information with the agency. There were no criminal PREA-related allegations made during the previous twelve months.

Provision (b):
Where sexual abuse is alleged, the agency shall use investigators who have received special training in sexual abuse investigations involving juvenile victims pursuant to § 115.334.

The YFM/PCM stated that the Children's Division, Out of Home Investigators (OHI) has received training in conducting criminal sexual abuse investigations.

Provision (c):
Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator.

The Assistant Regional Administrator stated that OHI investigators are trained on how to gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; investigators are required to interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator.

Provision (d):
The agency shall not terminate an investigation solely because the source of the allegation recants the allegation.

DYS Policy provides that an investigation will not be terminated solely because the source recants the allegation. The interviews confirmed what the practice will be in accordance with the Policy and standard.

Provision (e):
When the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.

Investigations that are criminal in nature are investigated by the Children's Division (CD) Investigative Section, Out of Home Investigations (OHI) investigators.

Provision (f):
The credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. No agency shall require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation.

DYS Policy states the credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and not be determined by the person's status as a resident or staff. Additionally, no resident who alleges sexual abuse will be subjected to a polygraph examination or other truth telling device as a condition for proceeding with the investigation of the allegation.

Provision (g):
Administrative investigations:
(1) Shall include an effort to determine whether staff actions or failures to act contributed to the abuse;
(2) Shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings.

The initial review of the Missouri Division of Youth Services (DYS) Policy 9.18 (Prison Rape Elimination Act of 2003) require staff to refer all alleged incidents of sexual abuse, harassment or misconduct to the CD-OHI or DLS (depending on the age of the resident) for investigation and determination of child abuse. These agencies will co-investigate with the appropriate local law enforcement agency who determines criminal charges. The MTVTC staff has received training in first responder duties and understanding the agency's protocol for obtaining usable physical evidence if a resident alleges sexual abuse, as confirmed by a review of training log, and curriculum.

Provision (h):
Criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible.

Interviews with the facility Youth Facility Manager/PCM, as well as a review of agency policy, indicate compliance of this provision of the standard. Although no training documentation was available for review at the time of the on-site audit, the Assistant Regional Administrator stated that appropriate training has been received by the Division's investigators and their experience to conduct a professional investigation. No criminal investigations have been conducted at the facility during this audit period.

Provision (i):
Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution.

The DYS Policy provides that all criminal investigations are referred to Children's Division (CD) Investigative Section, Out of Home Investigations (OHI) investigators. The OHI Division is responsible for referring for prosecution based on the outcome of the investigation. DYS Policy is inclusive of this provision of the standard.

Provision (j):
The agency shall retain all written reports referenced in paragraphs (g) and (h) of this section 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.

DYS Policy states all reports shall be retained while the abuser is incarcerated or employed by the agency, plus five years, unless applicable law requires a shorter period of retention.

Provision (k):
The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation.

DYS Policy and staff interviews support that the departure of the alleged abuser or victim from employment shall not provide a basis for terminating an investigation, which was also supported by interviews.

Provision (l):
Auditor is not required to audit this provision.

Provision (m):
When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.

DYS Policy states staff shall cooperate with any outside investigators and shall remain informed about the progress of the investigation. According to the YFM/PCM, the case number is provided when an outside investigation is conducted so that follow-up can occur as needed. There have not been any allegations of sexual abuse during this audit period.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding criminal and administrative agency investigations. All allegations of sexual abuse and sexual harassment are referred to a law enforcement agency.

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.

Documents Reviewed:
Missouri Division of Youth Services (DYS) 9.18 PREA Section I-III (PREA)
Child Welfare Manual 4.1.8.1.3, the Law on the Preponderance of Evidence Standard
Child Abuse or Neglect (CA/N) Investigation Reports

Interviews:
Youth Facility Manager/PCM
Assistant Regional Administrator

Provision (a):
The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated.

The Legal Elements of Child Abuse or Neglect (CA/N) states that investigators must gather all of the relevant evidence, which is both in favor and opposed to the finding. This includes contacting the alleged perpetrator, giving him/her the opportunity to tell his/her side of the story, and to allow the alleged perpetrator an opportunity to provide information contrary to the allegations. If the alleged perpetrator identifies witnesses who may have relevant evidence the CA/N Investigator should make a reasonable effort to contact and interview those witnesses. The CA/N Investigator must objectively review all of the evidence which is in favor of or contrary to the finding. The CA/N Investigator must objectively consider and balance the evidence in favor of or contrary to the finding; and in order to support a finding of child abuse or neglect by a Preponderance of Evidence (POE), the CA/N Investigator must be convinced that the evidence in favor of the finding outweighs the evidence against the finding, or is convinced that the evidence, when taken as a whole, shows that it is more probable than not that the alleged incident took place in this case.

Failure to apply the POE standard of proof may be a violation of the constitutional rights of the person who is accused of child abuse and/or neglect. A review of policy and interviews with outside agency representatives, and PREA Compliance Manager, indicated that MTVTC is aligned with the Policy.

Conclusion:
Based upon the review and analysis of the available evidence and the interviews, the Auditor has determined the facility is compliant with this standard regarding evidentiary standard for administrative investigations.

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 an agency 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.

Documents Reviewed:
DYS Policy 9.18 PREA Section IIIG2a
DYS Policy 9.18 PREA Section IIIG2b
DYS Policy 9.18 PREA Section IIIG2c 1-2
DYS Policy 9.18 PREA Section IIIG2d

Interviews:
Youth Facility Manager/PCM
Assistant Regional Administrator
Random Residents

Provision (a):
Following an investigation into a resident's allegation of sexual abuse suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.

Facility Policy DYS Policy 9.18 addresses the resident being informed by staff when the investigation is completed, informed of the outcome of the investigation, and the documentation of the notification. The YFM/PCM will remain abreast of an investigation conducted by any of the investigative entities by serving as the primary contact person(s), as determined by the interviews. The DYS Policy provides that any resident who makes an allegation of sexual abuse shall be informed verbally and in writing following an investigation by the YFM/PCM, as to whether or not the allegation was substantiated, unsubstantiated, or unfounded.

Provision (b):
If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident.

The DYS Policy states the facility shall request all relevant information from the investigating agency in order to inform the resident of the outcome of the investigation.

Provision (c):
Following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency shall subsequently inform the resident (unless the agency has determined that the allegation is unfounded) whenever:
(1) The staff member is no longer posted within the resident's unit;
(2) The staff member is no longer employed at the facility;

(3) The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or
(4) The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

MDYS Policy 9.18 PREA states: (1.) The employee is no longer assigned to the youth's treatment team; (2.) The employee is no longer employed at the facility; (3.) MDYS learns that the employee has been charged with a law violation related to a sexual abuse incident within the facility; or (4.) MDYS learns that the employee has been convicted of a law violation related to a sexual abuse incident within the facility.

Provision (d):
Following a resident's allegation that he or she has been sexually abused by another resident, the agency shall subsequently inform the alleged victim whenever:
(1) The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or
(2) The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

The DYS Policy 9.18 PREA Section IIIG2d provides that following a resident's allegation that he has been sexually abused by another resident; the alleged victim shall be subsequently informed whenever: (a.) The alleged abuser is criminally charged related to the sexual abuse; or (b.) The alleged abuser is adjudicated on a charge related to sexual abuse.

Provision (e):
All such notifications or attempted notifications shall be documented.

DYS Policy provides that all notifications or attempted notifications following a resident's allegation that he has been sexually abused by another resident be documented. There were no incidents reported within the past 12 months.

Provision (f):
Auditor is not required to audit this provision.

Conclusion:
The interviews with the identified staff confirm the Policy requirements and their knowledge of the process of reporting to a resident regarding the outcomes of an allegation of sexual abuse. Based on the review and analysis of the available documentation and interviews, the Auditor has determined the facility is compliant with this standard regarding reporting to residents.

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.

Documents Reviewed:
Missouri Division of Youth Services (DYS) 9.18 PREA Section I-III (PREA)
Child Welfare Manual 4.1.8.1.3 -The Law on the Preponderance of Evidence Standard
Child Abuse or Neglect (CA/N) Investigation Reports
Pre-Audit Questionnaire

Interview:
Youth Facility Manager/PCM
Assistant Regional Administrator
Random Staff

Provision (a):
Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

DYS employees may be subject to corrective measures or disciplinary action for violating provisions of the DSS Employee Handbook and divisional and departmental policies. Employees may also be subject to corrective measures and disciplinary action for reasons contained in 20-3.070(2) of the Rules of the Personnel Advisory Board and Personnel Division. In addition the Missouri Division of Youth Services (MDYS) Policy 9.18 (Prison Rape Elimination Act of 2003); Missouri Department of Social Services (DSS) Policy 2-101(Sexual Harassment/Inappropriate Conduct) and DSS Policy 2-124 (Discipline)

Provision (b):
Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse.

MDYS policy and procedures reviewed revealed that termination is the presumptive sanction for staff who has engaged in sexual abuse. Additionally staff may not escape sanctions by resigning. There has been no employee disciplined and/or terminated in the past 12 months for violation of the facility's sexual abuse or harassment policies. The Youth Facility Manager I interview validated her technical knowledge of the reporting process was consistent with MDYS policy and procedures.

Provision (c):
Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than engaging in sexual abuse) shall be 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.

The initial review of the Missouri Division of Youth Services (MDYS) Policy 9.18 (Prison Rape Elimination Act of 2003); Missouri Department of Social Services (DSS) Policy 2-101(Sexual Harassment/Inappropriate Conduct) and DSS Policy 2-124 (Discipline) disciplinary sanctions up to and including termination for violating the facility's sexual abuse or harassment policies. The FYM stated that disciplinary sanctions for violations of MDYS policies relating to sexual abuse or sexual harassment (other than engaging in sexual abuse) shall be 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.

Provision (d):
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, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

Employees who resign because they would have been terminated are reported to the local law enforcement, unless the activities were not clearly criminal. In addition, it shall be reported to relevant licensing bodies.

Conclusion:

Based upon the review of Policy and interview, the Auditor has determined the facility is compliant with this standard regarding disciplinary sanctions for staff. DYS Policy covers this standard. They had no incidents to report in this category.

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.

Documents Reviewed:
DYS Policy 9.18 PREA Section IIIH
DSS Policy 2-124 Discipline pg. 7
DSS Policy 2-101 Sexual Harassment/Inappropriate Conduct pg. 1
Copy of DSS Dismissal Letter

Interview:
Youth Facility Manager/PCM

Random Staff
Contractor

Provision (a):
Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.

The Missouri Division of Youth Services (MDYS) Policy 9.18 (Prison Rape Elimination Act of 2003) requires that volunteers and contractors in violation of the facility's policies and procedures regarding sexual abuse and harassment of residents will be reported to CD-OHI or DLS (depending on the age of the resident), Central Office and local law enforcement unless the activity was clearly not criminal and to relevant licensing bodies. The YFM/PCM stated that Contractors who engage in inappropriate contact with any Juvenile, including sexual assault or harassment, will be subject to a termination of their contract and a report made to the appropriate licensing authorities.

Provision (b):
The facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

The policies requires the facility staff to take remedial measures and prohibit future contact with residents in the case of any violation of the facility's sexual abuse and harassment policies by contractors or volunteers. This was verified during an interview with the Youth Facility Manager. The YFM/PCM stated that appropriate remedial measures would be taken and considerations whether to prohibit further contact with residents in the case of any other violation of the sexual abuse and sexual harassment policies by the contractor or volunteer. There have been no volunteers or contractors reported in the past 12 months for engaging in sexual abuse or harassment of a resident.

Conclusion:
Based upon the review and analysis of the available documentation, the Auditor has determined the facility is in compliant with this standard regarding corrective action for contractors and volunteers.

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 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 programs 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 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)

- 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.

Documents Reviewed:
DYS Policy 9.18 PREA Section IIIH
Pre-Audit Questionnaire

Interview:
Youth Facility Manager/PCM
Assistant Regional Administrator
Random Staff
Random Residents

Provision (a):
A resident may be subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse.

MDYS Policy 9.18 PREA Section IIIH addresses an administrative process for dealing with rule violations and references the policy that deals with discipline. Any resident found to have violated any of the agency's sexual abuse or sexual harassment policies will be offered therapy, counseling or other interventions designed to address and correct the underlining reasons for their conduct.

Provision (b):
Any disciplinary sanctions shall be 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. In the event a disciplinary sanction results in the isolation of a resident, agencies shall not deny the resident daily large-muscle exercise or access to any legally required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible.

The YFM/PCM stated that in the extreme event a disciplinary sanction results in the isolation of a resident, MTVTC shall not deny the resident exercise or access to any legally required educational programming or special education services. The residents may be provided daily visits by mental health and medical personnel and may have access to other programs and work opportunities to the extent possible, in accordance with Policy.

Provision (c):
The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed.

The Missouri Division of Youth Services (MDYS) Policy 9.18 (Prison Rape Elimination Act of (2003) states resident found to have violated any of the agency's sexual abuse or sexual harassment policies will be offered therapy, counseling or other interventions designed to address and correct the underlining reasons for their conduct. This was confirmed by the interview with the YFM/PCM.

Provision (d):
If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to offer the offending resident participation in such interventions. The agency may require participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, but not as a condition to access to general programming or education.

Any resident found to have violated any of the agency's sexual abuse or sexual harassment policies will be offered therapy, counseling or other interventions designed to address and correct the underlining reasons for their conduct. MTVTC staff provides each resident with information that includes their rights and responsibilities.

Provision (e):
The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

A review of Policy indicated that a resident found to have violated any of the agency's sexual abuse or sexual harassment policies will be offered therapy, counseling or other interventions designed to address and correct the underlining reasons for their conduct. The Youth Facility Manager I indicated that residents may also be referred for prosecution if the allegations were criminal.

Provision (f):
For the purpose of disciplinary action, a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.

The MDYS Policy states a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation. Resident found to have violated any of the agency's sexual abuse or sexual harassment policies will be offered therapy, counseling or other interventions designed to address and correct the underlining reasons for their conduct.

Provision (g):
An agency may, in its discretion, prohibit all sexual activity between residents and may discipline residents for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

The Policy prohibits any sexual conduct between residents. All such conduct is subject to disciplinary action. Court processes occur after determination the sexual activity was coerced.

Conclusion:
Based upon the review and analysis of the available documentation, the Auditor determined the facility is compliant with this standard regarding interventions and disciplinary sanctions for residents.

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 program 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.

Documents Reviewed:
DYS Policy 9.18 PREA Section III (I)1a
DYS Policy 7.2 Standards Section IIIA
PREA VULNERABILITY INFORMATION REVIEW (PVIR) SCREENING RESULTS AND FOLLOW-UP NOTIFICATION Form
Consent for Youth Age 18 and over to Report Allegations of Abuse

Interview:
Youth Facility Manager/PCM
Screening & Intake Staff
Medical Providers

Provision (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?

DYS Policy 9.18 PREA Section III (I)1a states that if the screening for abusiveness and victimization indicates that a youth has experienced prior victimization, whether it occurred in an institutional setting or in the community, the intake staff shall offer the youth a follow-up meeting with a Mental Health provider. Upon admission, and no more than 12 hours from admission, the Medical/Mental Health Screening will be conducted one-on-one with the juvenile and a staff member. This screening will be done by the staff member in such a way as to ensure the privacy of the juvenile. In compliance with PREA standards, if a juvenile reports any history of sexual abuse/assault on the Medical/Mental Health Screening that information will be provided to the Children's Division, Out of Home Investigations (OHI).

Provision (b):
If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, 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?

Interview with the YFM/PCM and a review of PREA Guidelines indicates that if the screening for abusiveness and victimization indicates that a youth has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, the intake staff shall offer the youth a follow-up meeting with a facility contracted Mental Health provider.

Provision (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 program assignments, or as otherwise required by Federal, State, or local law?

PREA Guidelines states that if the screening for abusiveness and victimization indicates that a youth has experienced prior victimization or has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, the intake staff shall offer the youth a follow-up meeting with a facility contracted Mental Health provider. The follow-up shall be completed within 14 days. All confidential data and files are labeled on a "need to know" basis. YFM/PCM and medical staff interviews verified the procedures.

Provision (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?

PREA Guidelines states that medical and mental health practitioners obtain Consent for Youth Age 18 and over to Report Allegations of Abuse 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. Interviews with medical staff confirmed that services would be provided, if requested by a youth.

Conclusion:
Based upon the review and analysis of the available documentation, the Auditor determined the facility is compliant with this standard regarding mental/medical screening.

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.

Documents Reviewed:
DYS Policy 9.18 PREA Section III (I) 2c-d
DYS Critical Incident Report and Review Form Intervention Services
Pre Audit Questionnaire

Interview:
Youth Facility Manager/PCM
Random Staff
Medical Providers
Random Residents

Provision (a) and (b):
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, staff 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. (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, staff shall ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening.

The DYS Policy 9.18 PREA, Guidelines, Medical and Mental Health Care provides that a resident who indicates during initial screening that they were a victim or perpetrator of sexual abuse shall be offered a follow-up visit with medical or mental health staff within 14 days of the intake screening. The policy states that if medical treatment is needed or if a forensic exam is required, appropriate agencies will be contacted, and juvenile will be transported to address those needs. Interview with the YFM/PCM revealed that victims shall be provided trauma assessment, crisis intervention, safety planning and address treatment needs. The contract Mental Health Specialist interviewed stated that all youth victims are seen as soon as possible for assessment and crisis intervention, as appropriate. Based on the results of the trauma assessment, the Mental Health Specialist shall develop a short-term trauma plan (i.e., psychiatric care, medication, mental health counseling, etc.) and an on-going counseling plan as needed. Youth are informed during their intake orientation that all such services will be provided without financial costs (also written in the PREA information the youth receive). Medical staff and the YFM/PCM staff verified the procedures.

Provision (c):
Any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law.

The Policy supports that any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law. The Auditor observed the resident files maintained in a secure manner. The files are secured in a locked cabinet behind a locked door, when the office is unoccupied. The Supervisor indicated that there is a list of individuals that have access to them.

Provision (d):
Medical and mental health practitioners shall 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.

The Policy provides that medical and mental health practitioners shall 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. The facility has created the Informed Consent form to document this type of situation.

Conclusion:
Based upon the review and analysis of the available evidence, the Auditor has determined the facility is compliant with this standard regarding medical and mental health screenings, and history of sexual abuse.

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.) ☐ 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.) ☐ 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.

Documents Reviewed:
DYS Policy 9.18 PREA Section III (I) 3
DYS Policy 6.1 Programmatic Rights of Youth and the Grievance Process Section III G
DYS Policy 7.2 Standards Section IIIA3
DYS Policy 7.3 Special Needs

DYS Policy 7.4 Access to Medical

Interviews:
Medical Staff
Mental Health Staff
Youth Facility Manager/PCM

Provision (a):
The facility shall 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.

DYS Policy requires that a medical and mental health evaluation and treatment be offered to resident victims of sexual abuse. According to the interviews, medical and mental health staff members are aware of the Policy mandates. A review of DYS Policy 7.4 Access to Medical and interviews, support medical and mental health evaluations and treatment will be offered to all residents who have been victimized by sexual abuse. Interviews with the clinical staff and observations confirmed on-going medical and mental health care will be provided as appropriate, including assessments and therapy.

Provision (b):
The evaluation and treatment of such victims shall 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.

Interviews with the contract clinical staff and observations confirmed on-going medical and mental health care will be provided as appropriate and will include but not limited to additional testing and medical services; medication management, if prescribed; individual counseling; trauma group; and referrals as needed. The Policy states that follow-up services will be provided.

Provision (c):
The facility shall provide such victims with medical and mental health services consistent with the community level of care.

Reviews of documented services provided by contract mental and medical providers indicate that services are consistent with the community level of care.

Provision (d):
Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests.

The Agency Policy states that a mental health specialist shall see the youth victim that has been sexually abused as soon as possible for assessment and crisis intervention, as appropriate. Based on the results of the trauma assessment, the mental health specialist shall develop a short-term trauma plan (i.e., psychiatric care, medication, mental health counseling, etc.) and an ongoing counseling plan as needed. Testing for Sexually Transmitted Diseases is provided, as medically appropriate.

Provision (e):
If pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services.

The YFM and medical providers stated that if pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services.

Provision (f):
Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate.

The DYS Policy 7.4 Access to Medical and interviews with medical/mental health providers and YFM/PCM stated that victims of sexual abuse will be provided tests for sexually transmitted infections as medically appropriate.

Provision (g):
Treatment services shall be 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.

All treatment services will be provided at no cost to the victim, according to Policy and staff interviews.

Provision (h):
The facility shall 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.

Facility Policy provides for attempts to be made for a mental health practitioner to conduct a mental health evaluation within 60 days on all known resident-on-resident abusers and offer appropriate treatment by mental health staff. The YFM/PCM stated that services will include but not be limited to individual, group and family counseling. Additionally, an evaluation or reassessment will be administered utilizing the PREA Vulnerability Information Review (PVIR) Screening Results and Notification Form.

Conclusion:
Based upon the review and analysis of the documentation, the Auditor has determined the facility is compliant with this standard regarding ongoing medical and mental health care for sexual abuse victims and abusers.

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.

Documents Reviewed:
DYS Policy 9.18 PREA Section IIIJ1a
DYS Policy 9.17 Critical Incidents Section IIIE
Critical Incident Review Forms

Interviews:
Assistant Regional Administrator
Youth Facility Manager/PCM
Incident Review Team Member

Provision (a):
The facility shall 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.

DYS Policy 9.17 Critical Incidents requires the facility to conduct 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. The YFM/PCM is familiar with the Policy requirements and stated that a report of the findings would be developed to include recommendations for improvement. The YFM/PCM further stated that they may implement the recommendations for improvement or shall document the reasons for not doing so. In that there were no substantiated or unsubstantiated findings that required a review, there were none completed in the previous 12 months.

Provision (b):
Such review shall ordinarily occur within 30 days of the conclusion of the investigation.

There is a Critical Incident Review Form that would be completed within 30 days of the outcome of an administrative or criminal investigation. The Policy requires that the reviews occur within 30 days of the conclusion of the investigation. Although there has not been an allegation of sexual abuse, the YFM/PCM confirmed incident reviews would occur within 30 days of the conclusion of an investigation in accordance with facility Policy and the standard.

Provision (c):
The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners.

The YFM/PCM stated that MTVTC incident review team members as will include YFM/PCM with input from line supervisors, medical staff, and Investigators when available.

Provision (d):
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, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submit such report to the facility head and PREA compliance manager.

The DYS Policy 9.17 Critical Incidents Section outlines the requirements of the standard for the areas to be assessed by the incident review team. The interview with the YFM/PCM, review of Policy and documentation method confirmed the incident review team will consider the factors identified in this standard provision regarding the results of the investigation, including: considering the make-up and vulnerability of the population such as gang affiliation; whether the resident identifies as gay, bisexual, transgender, or intersex; other group dynamics; assessment of the area relative to the allegations; and adequacy of staffing. The meeting would be documented, including recommendations and the document provided to the YFM/PCM.

Provision (e):
The facility shall implement the recommendations for improvement, or shall document its reasons for not doing so.

DYS Policy 9.17 Critical Incidents Section states the administration shall implement the recommendations for improvement, or shall document its reasons for not doing so. The YFM/PCM is familiar with this Policy requirement and the DYS Incident Review form would be used for documenting the incident review team meeting and it allows for documentation of the considerations of the standard. Additionally, the form provides for recommendations for improvement by the team members. There were no allegations of sexual abuse in the past 12 month that were in this category.

Conclusion:
Based upon the review and analysis of the available documentation, the Auditor has determined the facility is compliant with this standard regarding sexual abuse incident reviews.

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.

Documents Reviewed:
Data Collection Form
PREA Data (Annual Report)
PREA Pre-Audit Questionnaire

Interviews:
Assistant Regional Administrator
Youth Facility Manager/PCM

Provisions (a) & (c):
The agency shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The incident-based data collected shall 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.

The Policy requires the use of a standardized instrument with definitions to collect accurate, uniform data for every allegation of sexual abuse. The agency collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions.

Provision (b):
The agency shall aggregate the incident-based sexual abuse data at least annually.

Using the Data Collection Form, the agency collects, aggregates, and maintains the data, as required by the standard. The data instrument collects the data necessary to answer all questions from the USDOJ Survey of Sexual Violence. The YFM/PCM shall be responsible for compiling records and annually reporting statistical data to the State of Missouri who then compiles all statewide data and submits to Federal Bureau of Justice as required by the Department of Justice. The Policy and review of the annual report and data gathering instrument and other documents confirm the facility collects incident-based, uniform data regarding allegations of sexual abuse and sexual harassment. A standardized instrument and specific guidelines and definitions are used to assist in identifying the data.

Provision (d):
The agency shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

The facility maintains and collects various types of identified data and related documents regarding PREA. The Policy and review of the annual report and data gathering instrument and other documents confirm the facility collects incident-based, uniform data regarding allegations of sexual abuse and sexual harassment. A standardized instrument and specific guidelines and definitions are used to assist in identifying the data.

Provision (e):
The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents.

MTVTC does not contract with outside facilities for confinement of its residents.

Provision (f):
Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

The Policy states that upon request, MTVTC shall provide all such data from the previous calendar year to the Department of Justice no later than June 30. A request was not made for the previous calendar year.

Conclusion:
Based upon the review and analysis of the documentation, the Auditor has determined the facility is compliant with this standard regarding data collection.

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.

Documents Reviewed:
Missouri Department of Social Services website.
PREA Data (Annual Report)

Interviews:
Assistant Regional Administrator
Youth Facility Manager/PCM
PREA Coordinator

Provision (a) (b):
The agency shall 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. The agency's annual report must 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.

The facility has conducted the 2019 annual report and it is posted on the Missouri Department of Social Services website. The agency shall prepare an annual report of any findings with corrective actions for each facility, as well as the agency as a whole. The report includes a comparison of the current year's data. The Policy requires the review of data collected and aggregated in order to improve the PREA efforts.

Provision (c):
The agency's annual report should be 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

The interviews with the Assistant Regional Administrator revealed the collected and aggregated data is reviewed to assess and improve the effectiveness of the PREA related initiatives by identifying problem areas; developing and implementing corrective actions where needed; and preparing an annual report based on the collected data. The interviews supported the provisions of the Policy and the standard. The Policy also indicates an annual report will be prepared that will provide information regarding the facility's corrective actions in addressing sexual abuse.

Provision (d):
The agency indicates 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.

The annual report is approved as required by Policy, per the interviews and a review of the report by the auditor, the annual report reflects a comparison of the results of annual data, by calendar year. The annual report has been reviewed and the report is accessible to the public through the facility's website. There are no personal identifiers on the annual report.

Conclusion:
Based upon the review and analysis of the documentation, the Auditor has determined the facility is compliant with this standard regarding data review for corrective action.

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.

Documents Reviewed:
DYS Policy 9.18 PREA Section IIIJ2d
DYS Policy 9.18 PREA Section IIIJ2e
PREA: Data Collection, Review and Storage
Annual Report

Interviews:
Youth Facility Manager/PCM

Provision (a-b-c-d):
The agency shall ensure that data collected pursuant to § 115.387 are securely retained, readily available to the public at least annually through its website or, if it does not have one, through other means, remove all personal identifiers before making aggregated sexual abuse data publicly available and maintains 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.

A review of documentation on site and the agency website indicates that the agency meets the requirements of this standard. State of Missouri has a public website that features all federal PREA reports, PREA brochures, and information regarding PREA. The YFM/PCM stated that the Agency Policy provides that all data collected will be securely stored and maintained for at least 10 years after the initial collection date, unless State or local statutes require otherwise. According to DYS Policy 9.18 PREA Section IIIJ2e PREA Data Collection, Review and Storage, the aggregated sexual abuse data will be readily available to the public through the agency's website; the practice is that the report is posted on the agency's website. A review of the annual report verified there are no personal identifiers and it was observed posted on the website, as required. Related documentation in the facility was observed to be securely stored.

Conclusion:
Based upon the review and analysis of the documentation, interviews and observations, the Auditor has determined the facility is compliant with this standard regarding data storage, publication, and destruction.

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 inmates, residents, and detainees? ☒ 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.

Provision (a):
During the three-year period starting on August 20, 2013, and during each three-year period thereafter, the agency shall ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once.

All final reports are posted on the agency website. During this audit, the Auditor had access to previous audits, and had the ability to observe all areas of the audited facility.

Provision (b):
This is not the first audit for the company.

The Agency has ensured 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. PREA audits for the facility have been conducted as required for the initial three-year period. The facility, in conjunction with the Missouri Department of Youth Services, has embarked on fulfilling the auditing requirements for this second three-year period. The facility has provided the Auditor with the required documentation which have maintained as required by the standards and the auditing process.

Provision (h):

The Auditor shall have access to, and the ability to observe, all areas of the audited facility?

Upon completion of the entrance conference, a comprehensive site review of the facility was conducted and led by the YFM/FPCM. The tour included all areas of the facility. The facility was clean, in good repair, and well maintained. All areas were viewed, including the administration area, medical area, intake area, kitchen, dining room/visitation area, leisure/recreation areas, and the living unit area. PREA-related informational posters and the PREA audit notice were observed posted throughout the facility.

Provision (i):
The Auditor shall be permitted to request and receive copies of any relevant documents (including electronically stored information.

The Auditor received copies of all relevant documents (including electronically stored information) requested. A comprehensive site review was provided to the Auditor during the site visit and additional documentation was reviewed during the site visit. The staff members were cooperative in providing additional documentation as requested. The YFM/PCM provided appropriate workspaces which included conditions for conducting interviews in private with the residents and staff.

Provision (m):
The auditor shall be permitted to conduct private interviews with inmates, residents, and detainees.

A total of 13 residents were interviewed to include resident in the targeted categories recommended during the onsite phase of the audit:

Category of Residents	Number of Interviews
Random Residents	9
Residents who Identify as Gay or Bisexual	1
Residents with a Cognitive Disability	0
Residents Report of Sexual Abuse at this Facility	0
Residents with Physical Disability	0
Residents Report of Sexual Abuse During Intake	3
Residents who Identify as Transgender or Intersex	0

Provision (n):
Residents shall be permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel.

The notification of the on-site audit at Mt Vernon Treatment Center (MTVTC) was posted on June 18, 2020, six weeks prior to the date of the onsite audit. The posting of the notices was verified by photographs received electronically from the APC. Residents were permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel.

Conclusion
A review of documentation and interviews with the Administrative and the PREA Manager support the finding that this facility is in compliance with 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 within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. 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 has 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.

Provision (f):
The agency must publish on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports within 90 days of issuance by auditor. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. In the case of single facility agencies, the auditor shall ensure that the facility's last audit report was published. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision.

The Auditor confirmed the audit report was posted on the agency's website as is the practice with the facility. This report does not contain any personal identifying information and there were no conflicts of interest regarding the completion of the audit. The facility policies and other documentation were reviewed regarding compliance with the standards and have been identified in the report.

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.

Dwight L. Fondren, CCE August 24, 2020

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.