

Prison Rape Elimination Act (PREA) Audit Report Juvenile Facilities

☐ Interim ☒ Final

Date of Interim Audit Report: Click or tap here to enter text. ☐ N/A

If no Interim Audit Report, select N/A

Date of Final Audit Report: May 3, 2022

Auditor Information

Name: Robert Manville

Email: robertmanville9@gmail.cm

Company Name:

Mailing Address: 168 Dogwood Drive

City, State, Zip: Milledgeville, Ga. 31061

Telephone: 912-486-0004

Date of Facility Visit: 3/30-3/31/2022

Agency Information

Name of Agency: Abraxas Youth & Family Services

Governing Authority or Parent Agency (If Applicable): Click or tap here to enter text.

Address: 2840 Liberty Ave, Suite 300

City, State, Zip: Pittsburgh, PA 15222

Mailing Address: Click or tap here to enter text.

City, State, Zip: Click or tap here to enter text.

The Agency Is:

☐ Military

☐ Private for Profit

☒ Private not for Profit

☐ Municipal

☐ County

☐ State

☐ Federal

Agency Website with PREA Information: www.vivant.com/html/prea.html
<https://abraxasyfs.org/PREA.html>

Agency Chief Executive Officer

Name: Jon Swatsburg, MSW

Email: jswatsburg@abraxasyfs.com

Telephone: 717-253-5227

Agency-Wide PREA Coordinator

Name: Danny Cole, Ph.D.

Email: dancole@abraxasyfs.com

Telephone: 412-551-4007

PREA Coordinator Reports to:

Jon Swatsburg, MSW, CEO

Number of Compliance Managers who report to the PREA Coordinator:

7

Facility Information

Name of Facility: Leadership Development Program			
Physical Address: 10058 South Mountain Road		City, State, Zip: South Mountain, PA 17261	
Mailing Address: Building 6 10058 South Mountain Road		City, State, Zip: South Mountain, PA 17261	
The Facility Is:	<input type="checkbox"/> Military	<input type="checkbox"/> Private for Profit	<input checked="" type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input type="checkbox"/> State	<input type="checkbox"/> Federal
Facility Website with PREA Information: Abraxasyfs.org			
Has the facility been accredited within the past 3 years? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years): <input type="checkbox"/> ACA <input type="checkbox"/> NCCHC <input type="checkbox"/> CALEA <input checked="" type="checkbox"/> Other (please name or describe: Middle State Accreditation) <input type="checkbox"/> N/A			
If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe: Annual Pennsylvania Department of Human Services			
Facility Administrator/Superintendent/Director			
Name: Craig Schmidt			
Email: cschmidt@abraxasyfs.com		Telephone: 717-749-7440	
Facility PREA Compliance Manager			
Name: Bryan Coy			
Email: bcoy@abraxasyfs.com		Telephone: 717-749-7440	
Facility Health Service Administrator <input type="checkbox"/> N/A			
Name: Amy Randt			
Email: arandt@abraxasyfs.com		Telephone: 717-749-7440	
Facility Characteristics			
Designated Facility Capacity:	128		
Current Population of Facility:	42		
Average daily population for the past 12 months:	61		
Has the facility been over capacity at any point in the past 12 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		

Which population(s) does the facility hold?	<input type="checkbox"/> Females <input checked="" type="checkbox"/> Males <input type="checkbox"/> Both Females and Males	
Age range of population:	10-18	
Average length of stay or time under supervision	10-18 months	
Facility security levels/resident custody levels	Staff Secure	
Number of residents admitted to facility during the past 12 months	120	
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for <i>72 hours or more</i> :	120	
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for <i>10 days or more</i> :	118	
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	<input type="checkbox"/> Federal Bureau of Prisons <input type="checkbox"/> U.S. Marshals Service <input type="checkbox"/> U.S. Immigration and Customs Enforcement <input type="checkbox"/> Bureau of Indian Affairs <input type="checkbox"/> U.S. Military branch <input type="checkbox"/> State or Territorial correctional agency <input type="checkbox"/> County correctional or detention agency <input type="checkbox"/> Judicial district correctional or detention facility <input type="checkbox"/> City or municipal correctional or detention facility (e.g. police lockup or city jail) <input type="checkbox"/> Private corrections or detention provider <input type="checkbox"/> Other - please name or describe: Click or tap here to enter text. <input checked="" type="checkbox"/> N/A	
Number of staff currently employed by the facility who may have contact with residents:	88	
Number of staff hired by the facility during the past 12 months who may have contact with residents:	162	
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	6	
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	6	
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0	
Physical Plant		

<p>Number of buildings:</p> <p>Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.</p>	3
<p>Number of resident housing units:</p> <p>Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking Sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.</p>	5
Number of single resident cells, rooms, or other enclosures:	46
Number of multiple occupancy cells, rooms, or other enclosures:	16
Number of open bay/dorm housing units:	1
Number of segregation or isolation cells or rooms (for example, administrative, disciplinary, protective custody, etc.):	0
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Medical and Mental Health Services and Forensic Medical Exams	
Are medical services provided on-site?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Are mental health services provided on-site?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Where are sexual assault forensic medical exams provided? Select all that apply.	<input type="checkbox"/> On-site <input checked="" type="checkbox"/> Local hospital/clinic <input type="checkbox"/> Rape Crisis Center <input type="checkbox"/> Other (please name or describe: Click or tap here to enter text.)
Investigations	

Criminal Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:	0
When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.	<input type="checkbox"/> Facility investigators <input type="checkbox"/> Agency investigators <input checked="" type="checkbox"/> An external investigative entity
Select all external entities responsible for CRIMINAL INVESTIGATIONS : Select all that apply (N/A if no external entities are responsible for criminal investigations)	<input type="checkbox"/> Local police department <input type="checkbox"/> Local sheriff's department <input checked="" type="checkbox"/> State police <input type="checkbox"/> A U.S. Department of Justice component <input type="checkbox"/> Other (please name or describe) <input type="checkbox"/> N/A
Administrative Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	4
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: <i>Select all that apply</i>	<input checked="" type="checkbox"/> Facility investigators <input type="checkbox"/> Agency investigators <input type="checkbox"/> An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS : Select all that apply (N/A if no external entities are responsible for administrative investigations)	<input type="checkbox"/> Local police department <input type="checkbox"/> Local sheriff's department <input type="checkbox"/> State police <input type="checkbox"/> A U.S. Department of Justice component <input type="checkbox"/> Other (please name or describe) <input type="checkbox"/> N/A

Summary of Audit Findings

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

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

Standards Exceeded

Number of Standards Exceeded: 5

List of Standards Exceeded: **Standard 115.321: Evidence protocol and forensic medical examinations; Standard 115.341: Screening for risk of victimization and abusiveness; Standard 115.351: Resident reporting; Standard 115.361: Staff and agency reporting duties Standard; 115.365: Coordinated response**

Standards Met

Number of Standards Met: 38

Standards Not Met

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

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

Post-Audit Reporting Information

General Audit Information	
Onsite Audit Dates	
1. Start date of the onsite portion of the audit:	3/30/2022
2. End date of the onsite portion of the audit:	3/31/2022
Outreach	
3. Did you attempt to communicate with community-based organization(s) or victim advocates who provide services to this facility and/or who may have insight into relevant conditions in the facility?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes, identify the community-based organizations or victim advocates with whom you corresponded:	Women In Need
Audited Facility Information	
4. Designated Facility Capacity:	128
5. Average daily population for the past 12 months:	61
6. Number of inmate/resident/detainee housing units: DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house inmates of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.	5
7. Does the facility ever hold youthful inmates or youthful/juvenile detainees?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A for the facility type audited (i.e., Community Confinement Facility or Juvenile Facility)
Audited Facility Population on Day One of the Onsite Portion of the Audit	
Inmates/Residents/Detainees	

8. Enter the total number of inmates/residents/detainees housed at the facility as of the first day of the onsite portion of the audit:	42
9. Enter the total number of youthful inmates or youthful/juvenile detainees housed at the facility on the first day of the onsite portion of the audit:	0
10. Enter the total number of inmates/residents/detainees with a physical disability housed at the facility as of the first day of the onsite portion of the audit:	0
11. Enter the total number of inmates/residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) housed at the facility as of the first day of the onsite portion of the audit:	0
12. Enter the total number of inmates/residents/detainees who are Blind or have low vision (visually impaired) housed at the facility on the first day of the onsite portion of the audit:	0
13. Enter the total number of inmates/residents/detainees who are Deaf or hard-of-hearing housed at the facility on the first day of the onsite portion of the audit:	0
14. Enter the total number of inmates/residents/detainees who are Limited English Proficient (LEP) housed at the facility as of the first day of the onsite portion of the audit:	0
15. Enter the total number of inmates/residents/detainees who identify as lesbian, gay, or bisexual housed at the facility as of the first day of the onsite portion of the audit:	1
16. Enter the total number of inmates/residents/detainees who identify as transgender, or intersex housed at the facility as of the first day of the onsite portion of the audit:	0
17. Enter the total number of inmates/residents/detainees who reported sexual abuse in this facility who are housed at the facility as of the first day of the onsite portion of the audit:	0
18. Enter the total number of inmates/residents/detainees who reported sexual harassment in this facility who are housed at the facility as of the first day of the onsite portion of the audit:	0
19. Enter the total number of inmates/residents/detainees who disclosed prior sexual victimization during risk screening housed at the facility as of the first day of the onsite portion of the audit:	2
20. Enter the total number of inmates/residents/detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization housed at the facility as of the first day of the onsite portion of the audit:	0
21. Enter the total number of inmates/residents/detainees who are or were ever placed in segregated housing/isolation for having reported sexual abuse in this facility as of the first day of the onsite portion of the audit:	0

22. Enter the total number of inmates/residents detained solely for civil immigration purposes housed at the facility as of the first day of the onsite portion of the audit:	0.
23. Provide any additional comments regarding the population characteristics of inmates/residents/detainees in the facility as of the first day of the onsite portion of	Click or tap here to enter text.

<p>the audit (e.g., groups not tracked, issues with identifying certain populations).</p> <p><i>Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.</i></p>	
<p align="center">Staff, Volunteers, and Contractors <i>Include all full- and part-time staff employed by the facility, regardless of their level of contact with inmates/residents/detainees</i></p>	
<p>24. Enter the total number of STAFF, including both full- and part-time staff employed by the facility as of the first day of the onsite portion of the audit:</p>	<p align="center">89</p>
<p>25. Enter the total number of CONTRACTORS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:</p>	<p align="center">0</p>
<p>26. Enter the total number of VOLUNTEERS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:</p>	<p align="center">0</p>
<p>27. Provide any additional comments regarding the population characteristics of staff, volunteers, and contractors who were in the facility as of the first day of the onsite portion of the audit.</p> <p><i>Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.</i></p>	<p align="center">Click or tap here to enter text.</p>
<p align="center">Interviews</p>	
<p align="center">Inmate/Resident/Detainee Interviews</p>	
<p align="center"><i>Random Inmate/Resident/Detainee Interviews</i></p>	
<p>28. Enter the total number of RANDOM INMATES/RESIDENTS/DETAINEES who were interviewed:</p>	<p align="center">18</p>
<p>29. Select which characteristics you considered when you selected random inmate/resident/detainee interviewees:</p>	<p> <input checked="" type="checkbox"/> Age <input type="checkbox"/> Race <input checked="" type="checkbox"/> Ethnicity (e.g., Hispanic, Non-Hispanic) <input type="checkbox"/> Length of time in the facility <input checked="" type="checkbox"/> Housing assignment <input checked="" type="checkbox"/> Gender <input checked="" type="checkbox"/> Other (describe) Previous Program Placements <input type="checkbox"/> None (explain) Click or tap here to enter text. </p>
<p>30. How did you ensure your sample of random inmate/resident/detainee interviewees was geographically diverse?</p>	<p>I interviewed residents assigned to the facility from West Virginia and Pennsylvania. The assignments are based on resident's needs.</p>
<p>31. Were you able to conduct the minimum number of random inmate/resident/detainee interviews?</p>	<p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>a. If no, explain why it was not possible to interview the minimum number of random inmate/resident/detainee interviews:</p>	<p align="center">Click or tap here to enter text.</p>
<p>32. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation, etc.).</p>	<p align="center">There were no barriers to completing the interviews.</p>

Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.

Targeted Inmate/Resident/Detainee Interviews

33. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed:

As stated in the PREA Auditor Handbook, the breakdown of targeted interviews is intended to guide auditors in interviewing the appropriate cross-section of inmates/residents/detainees who are the most vulnerable to sexual abuse and sexual harassment. When completing questions regarding targeted inmate/resident/detainee interviews below, remember that an interview with one inmate/resident/detainee may satisfy multiple targeted interview requirements. These questions are asking about the number of interviews conducted using the targeted inmate/resident/detainee protocols.

For example, if an auditor interviews an inmate who has a physical disability, is being held in segregated housing due to risk of sexual victimization, and disclosed prior sexual victimization, that interview would be included in the totals for each of those questions. Therefore, in most cases, the sum of all the following responses to the targeted inmate/resident/detainee interview categories will exceed the total number of targeted inmates/residents/detainees who were interviewed.

If a particular targeted population is not applicable in the audited facility, enter "0".

3

34. Enter the total number of interviews conducted with youthful inmates or youthful/juvenile detainees using the "Youthful Inmates" protocol:

N/A

a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:

- ☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees.
- ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).

Review of the PAQ and contract stipulations.

35. Enter the total number of interviews conducted with inmates/residents/detainees with a physical disability using the "Disabled and Limited English Proficient Inmates" protocol:

0

a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:

- ☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees.
- ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

<p>b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).</p>	<p>I interviewed the nurse, who indicated there were no resident with any physical disabilities</p>
<p>36. Enter the total number of interviews conducted with inmates/residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) using the “Disabled and Limited English Proficient Inmates” protocol:</p>	<p>0</p>
<p>a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:</p>	<p><input checked="" type="checkbox"/> Facility said there were “none here” during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees.</p> <p><input type="checkbox"/> The inmates/residents/detainees in this targeted category declined to be interviewed.</p>
<p>b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).</p>	<p>I interviewed the clinical director who indicated there were no cognitive disabled residents at the facility.</p>
<p>37. Enter the total number of interviews conducted with inmates/residents/detainees who are Blind or have low vision (visually impaired) using the “Disabled and Limited English Proficient Inmates” protocol:</p>	<p>0</p>
<p>a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:</p>	<p><input checked="" type="checkbox"/> Facility said there were “none here” during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees.</p> <p><input type="checkbox"/> The inmates/residents/detainees in this targeted category declined to be interviewed.</p>
<p>b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).</p>	<p>I interviewed the nurse, who indicated there were no resident with any physical disabilities. I also did not see any disabled residents during the tour.</p>
<p>38. Enter the total number of interviews conducted with inmates/residents/detainees who are Deaf or hard-of-hearing using the “Disabled and Limited English Proficient Inmates” protocol:</p>	<p>0</p>
<p>a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:</p>	<p><input checked="" type="checkbox"/> Facility said there were “none here” during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees.</p> <p><input type="checkbox"/> The inmates/residents/detainees in this targeted category declined to be interviewed.</p>
<p>b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).</p>	<p>I interviewed the nurse, who indicated there were no resident with any physical disabilities</p>

39. Enter the total number of interviews conducted with inmates/residents/detainees who are Limited English Proficient (LEP) using the “Disabled and Limited English Proficient Inmates” protocol:	0
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	<input checked="" type="checkbox"/> Facility said there were “none here” during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. <input type="checkbox"/> The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	I asked resident and staff if there were anyone at the facility that did not speak English.
40. Enter the total number of interviews conducted with inmates/residents/detainees who identify as lesbian, gay, or bisexual using the “Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates” protocol:	1
a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	<input type="checkbox"/> Facility said there were “none here” during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. <input type="checkbox"/> The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	Click or tap here to enter text.
41. Enter the total number of interviews conducted with inmates/residents/detainees who identify as transgender or intersex “Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates” protocol:	0

a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	<input checked="" type="checkbox"/> Facility said there were “none here” during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. <input type="checkbox"/> The inmates/residents/detainees in this targeted category declined to be interviewed.
b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	I interview the nurse and facility director who stated they did not have any transgender or intersex resident at the facility.
42. Enter the total number of interviews conducted with inmates/residents/detainees who reported sexual abuse in this facility using the “Inmates who Reported a Sexual Abuse” protocol:	0

<p>a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:</p>	<p><input checked="" type="checkbox"/> Facility said there were “none here” during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees.</p> <p><input type="checkbox"/> The inmates/residents/detainees in this targeted category declined to be interviewed.</p>
<p>b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).</p>	<p>Interviewed direct care staff, residents, clinical supervisor, medical and Facility Administrator.</p>
<p>43. Enter the total number of interviews conducted with inmates/residents/detainees who disclosed prior sexual victimization during risk screening using the “Inmates who Disclosed Sexual Victimization during Risk Screening” protocol:</p>	<p>2</p>
<p>a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:</p>	<p><input type="checkbox"/> Facility said there were “none here” during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees.</p> <p><input type="checkbox"/> The inmates/residents/detainees in this targeted category declined to be interviewed.</p>
<p>b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).</p>	<p>Click or tap here to enter text.</p>
<p>44. Enter the total number of interviews conducted with inmates/residents/detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization using the “Inmates Placed in Segregated Housing (for Risk of Sexual Victimization/Who Alleged to have Suffered Sexual Abuse)” protocol:</p>	<p>0</p>
<p>a. If 0, select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:</p>	<p><input checked="" type="checkbox"/> Facility said there were “none here” during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees.</p> <p><input type="checkbox"/> The inmates/residents/detainees in this targeted category declined to be interviewed.</p>
<p>b. If 0, discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).</p>	<p>Interviewed direct care staff, residents, clinical supervisor, medical and Facility Administrator.</p>
<p>45. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation, etc.).</p> <p><i>Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.</i></p>	<p>The facility housed 42 residents; 18 residents were interviewed. Residents that came from other program were oversampled and included all residents that transferred to the facility from other programs.</p>
<p>Staff, Volunteer, and Contractor Interviews</p>	
<p><i>Random Staff Interviews</i></p>	

46. Enter the total number of RANDOM STAFF who were interviewed:	15
47. Select which characteristics you considered when you selected RANDOM STAFF interviewees (select all that apply):	<input type="checkbox"/> Length of tenure in the facility <input type="checkbox"/> Shift assignment <input type="checkbox"/> Work assignment <input type="checkbox"/> Rank (or equivalent) <input checked="" type="checkbox"/> Other (describe) All staff that were working at the facility on each shift on each day of the onsite audit were interviewed. <input type="checkbox"/> None (explain) Click or tap here to enter text.
48. Were you able to conduct the minimum number of RANDOM STAFF interviews?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
a. If no, select the reasons why you were not able to conduct the minimum number of RANDOM STAFF interviews (select all that apply):	<input type="checkbox"/> Too many staff declined to participate in interviews <input type="checkbox"/> Not enough staff employed by the facility to meet the minimum number of random staff interviews (Note: select this option if there were not enough staff employed by the facility or not enough staff employed by the facility to interview for both random and specialized staff roles). <input type="checkbox"/> Not enough staff available in the facility during the onsite portion of the audit to meet the minimum number of random staff interviews. <input type="checkbox"/> Other (describe) Click or tap here to enter text.
b. Describe the steps you took to select additional RANDOM STAFF interviewees and why you were still unable to meet the minimum number of random staff interviews:	Click or tap here to enter text.
49. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, etc.). <i>Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.</i>	he center is maintaining staff to meet the mandatory ratio of staff to residents. In order to accomplish this mandate staff or working overtime and callbacks are utilized.

<p align="center"><i>Specialized Staff, Volunteers, and Contractor Interviews</i></p> <p align="center"><u>Staff in some facilities may be responsible for more than one of the specialized staff duties. Therefore, more than one interview protocol may apply to an interview with a single staff member and that interview would satisfy multiple specialized staff interview requirements.</u></p>	
50. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	8
51. Were you able to interview the Agency Head?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
a. If no, explain why it was not possible to interview the Agency Head:	Click or tap here to enter text.
52. Were you able to interview the Warden/Facility Director/Superintendent or their designee?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
a. If no, explain why it was not possible to interview the Warden/Facility Director/Superintendent or their designee:	Click or tap here to enter text.

53. Were you able to interview the PREA Coordinator?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
a. If no, explain why it was not possible to interview the PREA Coordinator:	Click or tap here to enter text.
54. Were you able to interview the PREA Compliance Manager?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (N/A if the agency is a single facility agency or is otherwise not required to have a PREA Compliance Manager per the Standards)
a. If no, explain why it was not possible to interview the PREA Compliance Manager:	Click or tap here to enter text.

55. Select which SPECIALIZED STAFF roles were interviewed as part of this audit (select all that apply):	<input type="checkbox"/> Agency contract administrator <input checked="" type="checkbox"/> Intermediate or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment <input type="checkbox"/> Line staff who supervise youthful inmates (if applicable) <input type="checkbox"/> Education and program staff who work with youthful inmates (if applicable) <input checked="" type="checkbox"/> Medical staff <input checked="" type="checkbox"/> Mental health staff <input type="checkbox"/> Non-medical staff involved in cross-gender strip or visual searches <input checked="" type="checkbox"/> Administrative (human resources) staff <input checked="" type="checkbox"/> Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) staff <input checked="" type="checkbox"/> Investigative staff responsible for conducting administrative investigations
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	<input type="checkbox"/> Investigative staff responsible for conducting criminal investigations <input checked="" type="checkbox"/> Staff who perform screening for risk of victimization and abusiveness <input type="checkbox"/> Staff who supervise inmates in segregated housing/residents in isolation <input checked="" type="checkbox"/> Staff on the sexual abuse incident review team <input checked="" type="checkbox"/> Designated staff member charged with monitoring retaliation <input type="checkbox"/> First responders, both security and non-security staff <input checked="" type="checkbox"/> Intake staff <input type="checkbox"/> Other (describe) Click or tap here to enter text.
56. Did you interview VOLUNTEERS who may have contact with inmates/residents/detainees in this facility?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
a. Enter the total number of VOLUNTEERS who were interviewed:	0
b. Select which specialized VOLUNTEER role(s) were interviewed as part of this audit (select all that apply):	<input type="checkbox"/> Education/programming <input type="checkbox"/> Medical/dental <input type="checkbox"/> Mental health/counseling <input type="checkbox"/> Religious <input type="checkbox"/> Other
57. Did you interview CONTRACTORS who may have contact with inmates/residents/detainees in this facility?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
a. Enter the total number of CONTRACTORS who were interviewed:	0

b. Select which specialized CONTRACTOR role(s) were interviewed as part of this audit (select all that apply):	<input type="checkbox"/> Security/detention <input type="checkbox"/> Education/programming <input type="checkbox"/> Medical/dental <input type="checkbox"/> Food service <input type="checkbox"/> Maintenance/construction <input type="checkbox"/> Other
58. Provide any additional comments regarding selecting or interviewing specialized staff (e.g., any populations you oversampled, barriers to completing interviews, etc.). <i>Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.</i>	The facility does not have any contractor or volunteers at this time. The facility did not have any contractor on site during the audit. The contractor the facility utilizes are vending machine staff and specialized medical staff.

Site Review and Documentation Sampling

Site Review

PREA Standard 115.401(h) states, "The auditor shall have access to, and shall observe, all areas of the audited facilities." In order to meet the requirements in this Standard, the site review portion of the onsite audit must include a thorough examination of the entire facility. The site review is not a casual tour of the facility. It is an active, inquiring process that includes talking with staff and inmates to determine whether, and the extent to which, the audited facility's practices demonstrate compliance with the Standards. Note:

discussions related to testing critical functions are expected to be included in the relevant Standard-specific overall determination narratives.

59. Did you have access to all areas of the facility?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
a. If no, explain what areas of the facility you were unable to access and why.	Click or tap here to enter text.
Was the site review an active, inquiring process that included the following:	
60. Reviewing/examining all areas of the facility in accordance with the site review component of the audit instrument?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
a. If no, explain why the site review did not include reviewing/examining all areas of the facility.	Click or tap here to enter text.
61. Testing and/or observing all critical functions in the facility in accordance with the site review component of the audit instrument (e.g., intake process, risk screening process, PREA education)?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
a. If no, explain why the site review did not include testing and/or observing all critical functions in the facility.	Click or tap here to enter text.
62. Informal conversations with inmates/residents/detainees during the site review (encouraged, not required)?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
63. Informal conversations with staff during the site review (encouraged, not required)?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<p>64. Provide any additional comments regarding the site review (e.g., access to areas in the facility, observations, tests of critical functions, or informal conversations).</p> <p><i>Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.</i></p>	<p>During the comprehensive tour of the facility, posted signs were also observed regarding general PREA information and contact numbers for reporting sexual abuse or sexual harassment. Also presented was the phone number and address for the Women In Need and the telephone number for the PA ChildLine. Telephone calls to the Women In Need and the PA ChildLine were answered by a live person. There is an office that is utilized by the resident to make these phone calls. During the tour, youth were observed to be under constant supervision of the staff while involved in educational programs. PREA signage (in bold and colorful print) was displayed in all areas frequented by the residents. They include how to make an allegation, end the silence, PREA notice of audit, telephone numbers, and general information about PREA poster. The tour included all areas of the facility which included but was not limited to intake, all housing units, medical, food services, programming, and education areas. The facility was clean and well maintained. Signs are located in the entrance of each housing unit that states, staff, contractors, and volunteers announced themselves prior to entering the housing area of the opposite gender. During the tour there was always a minimum of a one to six or less ratio to residents. In the early morning visit to the facility, there was a ratio of 1 to 6 in the housing units during the day. During the tour of the facility on the second morning there was a 1 to 6 ratio. Questions were</p>

	<p>answered by staff during informal interviews regarding resident activities and program services as the tour progressed throughout the facility. The site visit also included the outside grounds. During the tour, the intake process was described, and the daily scheduled activities and staff supervision were discussed by the Superintendent/PREA Manager. There were no new admissions during the site visit. Staff readily explained activities as different facility areas were visited. Resident informal interviews were minimized due to all residents being a classroom setting and to interrupt the classroom would be counterproductive. There were some random interviews while visiting areas of the facility when school was dismissed. However, again this was limited due to resident being ushered to their assigned therapeutic groups. Several of the resident showed me the office that can be used to talk to your lawyer, parent and to make a call to the local law enforcement or to the victim advocate. Staff of the opposite gender, must announce their presence when entering the housing unit or any area where a resident shower, change clothes, or perform bodily functions. All residents interviewed stated the staff members announce their presence prior to entering the housing unit. This practice was experienced and observed during the tour. The shower area has shower curtains for privacy. The facility has individual rooms. Resident indicated that staff knock on their door prior to looking in the room during count. The medical room has a shower around the examination area and the staff indicated they close the door and use the shower when they examine residents. Medical Request Forms, PREA/grievance forms, and the locked boxes for each are posted in the common area, accessible to all residents, staff and visitors. All residents have access to writing utensils needed for completing the forms. The staff to resident ratio was observed to be met in all areas of the facility during the on-site tour. The camera monitoring system, in addition to mirrors, support the direct supervision provided by staff.</p>
<p align="center">Documentation Sampling</p>	
<p><i>Where there is a collection of records to review—such as staff, contractor, and volunteer training records; background check records; supervisory rounds logs; risk screening and intake processing records; inmate education records; medical files; and investigative files—auditors must self-select for review a representative sample of each type of record.</i></p>	
<p>65. In addition to the proof documentation selected by the agency or facility and provided to you, did you also conduct an auditor-selected sampling of documentation?</p>	<p><input checked="checked" type="checkbox"/> Yes <input type="checkbox"/> No</p>

66. Provide any additional comments regarding selecting additional documentation (e.g., any documentation you oversampled, barriers to selecting additional documentation, etc.).

Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.

The auditor requested random personnel background checks and reviewed 10 employee training records, two contractor files, and two volunteer files. The employee records included three staff that had been employed at the facility more than 5 years, 3 of the staff were promoted and four of the staff were employed in the last 12 months check was completed and is maintained on file in the personnel's office. The auditor requested some specific and some random training files for employees. Including in the specific list was training staff, director, PCM, shift supervisor and ten random monitors. Medical staff receive the same specialized training as Department medical staff. The training files were requested and reviewed. The medical and mental health staff have received specialized training for Sexual Abuse and victimization. Ten residential records were reviewed utilizing the worksheet provided by the PREA Resource Center. Included in the review was age, date of arrival, date of initial PREA orientation, date of comprehensive PREA training, initial Vulnerability Screening and rescreening after resident had been at the facility twenty-five to thirty days. A review of the residential records also included resident referrals for mental health or victim advocate programs. The resident's file contained documentation of Intake Screening, Intake PREA notification, rescreening and formalized PREA education. All time requirements were met on each area. Logbook documentation of PREA rounds were reviewed during the tour. The auditor asked to review Investigative files. There was one file that is ongoing that the auditor was able to review, however there were no files available during the audit.

Sexual Abuse and Sexual Harassment Allegations and Investigations in this Facility

Sexual Abuse and Sexual Harassment Allegations and Investigations Overview

Remember the number of allegations should be based on a review of all sources of allegations (e.g., hotline, third-party, grievances) and should not be based solely on the number of investigations conducted.

Note: For question brevity, we use the term "inmate" in the following questions. Auditors should provide information on inmate, resident, or detainee sexual abuse allegations and investigations, as applicable to the facility type being audited.

67. Total number of SEXUAL ABUSE allegations and investigations overview during the 12 months preceding the audit, by incident type:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	# of sexual abuse allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
<u>Inmate-on-inmate sexual abuse</u>	3	3	0	0
<u>Staff-on-inmate sexual abuse</u>	0	0	0	0
Total	3	3	0	0

<p>a. If you were unable to provide any of the information above, explain why this information could not be provided.</p>	<p>Click or tap here to enter text.</p>
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68. Total number of SEXUAL HARASSMENT allegations and investigations overview during the 12 months preceding the audit, by incident type:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	# of sexual harassment allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
<u>Inmate-on-inmate sexual harassment</u>	0	0	0	0
<u>Staff-on-inmate sexual harassment</u>	0	0	0	0
Total	0	0	0	0

<p>a. If you were unable to provide any of the information above, explain why this information could not be provided.</p>	<p>Click or tap here to enter text.</p>
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Sexual Abuse and Sexual Harassment Investigation Outcomes

Sexual Abuse Investigation Outcomes

Note: these counts should reflect where the investigation is currently (i.e., if a criminal investigation was referred for prosecution and resulted in a conviction, that investigation outcome should only appear in the count for "convicted.") Do not double count. Additionally, for question brevity, we use the term "inmate" in the following questions. Auditors should provide information on inmate, resident, and detainee sexual abuse investigation files, as applicable to the facility type being audited.

69. Criminal SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	Ongoing	Referred for Prosecution	Indicted/Court Case Filed	Convicted/Adjudicated	Acquitted
<u>Inmate-on-inmate sexual abuse</u>	3	0	0	0	0
<u>Staff-on-inmate sexual abuse</u>	0	0	0	0	0
Total	0	0	0	0	0

<p>a. If you were unable to provide any of the information above, explain why this information could not be provided.</p>	<p>Click or tap here to enter text.</p>
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70. Administrative SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	Ongoing	Unfounded	Unsubstantiated	Substantiated
<u>Inmate-on-inmate sexual abuse</u>	3	0	0	0
<u>Staff-on-inmate</u>	0	0	0	0

sexual abuse				
Total	0	0	0	0

a. If you were unable to provide any of the information above, explain why this information could not be provided.

Click or tap here to enter text.

Sexual Harassment Investigation Outcomes

Note: these counts should reflect where the investigation is currently. Do not double count. Additionally, for question brevity, we use the term "inmate" in the following questions. Auditors should provide information on inmate, resident, and detainee sexual harassment investigation files, as applicable to the facility type being audited.

71. Criminal SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	Ongoing	Referred for Prosecution	Indicted/Court Case Filed	Convicted/Adjudicated	Acquitted
<u>Inmate-on-inmate</u> sexual harassment	0	0	0	0	0
<u>Staff-on-inmate</u> sexual harassment	0	0	0	0	0
Total	0	0	0	0	0

a. If you were unable to provide any of the information above, explain why this information could not be provided.

Click or tap here to enter text.

72. Administrative SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

Instructions: If you are unable to provide information for one or more of the fields below, enter an "X" in the field(s) where information cannot be provided.

	Ongoing	Unfounded	Unsubstantiated	Substantiated
<u>Inmate-on-inmate</u> sexual harassment	0	0	0	0
<u>Staff-on-inmate</u> sexual harassment	0	0	0	0
Total	0	0	0	0

a. If you were unable to provide any of the information above, explain why this information could not be provided.

Click or tap here to enter text.

Sexual Abuse and Sexual Harassment Investigation Files Selected for Review

Sexual Abuse Investigation Files Selected for Review

73. Enter the total number of SEXUAL ABUSE investigation files reviewed/sampled:

1

a. If 0, explain why you were unable to review any sexual abuse investigation files:

The three allegations resolve around one incident in which a female resident touch the clothed

	breast of three residents. It is being investigated as one investigation and so there was only 1 investigative file.
74. Did your selection of SEXUAL ABUSE investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (N/A if you were unable to review any sexual abuse investigation files)
Inmate-on-inmate sexual abuse investigation files	
75. Enter the total number of INMATE-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	1
76. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (N/A if you were unable to review any inmate-on-inmate sexual abuse investigation files)
77. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A (N/A if you were unable to review any inmate-on-inmate sexual abuse investigation files)
Staff-on-inmate sexual abuse investigation files	
78. Enter the total number of STAFF-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
79. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A (N/A if you were unable to review any staff-on-inmate sexual abuse investigation files)
80. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A (N/A if you were unable to review any staff-on-inmate sexual abuse investigation files)
<i><u>Sexual Harassment Investigation Files Selected for Review</u></i>	
81. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	0
a. If 0, explain why you were unable to review any sexual harassment investigation files:	There were no allegation of sexual harassment
82. Did your selection of SEXUAL HARASSMENT investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A (N/A if you were unable to review any sexual harassment investigation files)

Inmate-on-inmate sexual harassment investigation files	
83. Enter the total number of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
84. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files include criminal investigations?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A (N/A if you were unable to review any inmate-on-inmate sexual harassment investigation files)
85. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A (N/A if you were unable to review any inmate-on-inmate sexual harassment investigation files)
Staff-on-inmate sexual harassment investigation files	

86. Enter the total number of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
87. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include criminal investigations?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A (N/A if you were unable to review any staff-on-inmate sexual harassment investigation files)
88. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A (N/A if you were unable to review any staff-on-inmate sexual harassment investigation files)
89. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files. <i>Note: as this text will be included in the audit report, please do not include any personally identifiable information or other information that could compromise the confidentiality of any persons in the facility.</i>	There was an allegation that one resident inappropriately touched the clothed breast of three residents. The investigation was referred to PA. State Police and the case is ongoing.
Support Staff Information	
DOJ-certified PREA Auditors Support Staff	
90. Did you receive assistance from any DOJ-CERTIFIED PREA AUDITORS at any point during this audit? <i>Remember: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
a. If yes, enter the TOTAL NUMBER OF DOJ-CERTIFIED PREA AUDITORS who provided assistance at any point during the audit:	Click or tap here to enter text.
Non-certified Support Staff	
91. Did you receive assistance from any NON-CERTIFIED SUPPORT STAFF at any point during this audit? <i>Remember: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.</i>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
a. If yes, enter the TOTAL NUMBER OF NON-CERTIFIED SUPPORT STAFF who provided assistance at any point during the audit:	Click or tap here to enter text.
Auditing Arrangements and Compensation	
92. Who paid you to conduct this audit?	<input checked="" type="checkbox"/> The audited facility or its parent agency <input type="checkbox"/> My state/territory or county government (if you audit as part of a consortium or circular auditing arrangement, select this option) <input type="checkbox"/> A third-party auditing entity (e.g., accreditation body, consulting firm) <input type="checkbox"/> Other

PREVENTION PLANNING

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

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

115.311 (a)

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

115.311 (b)

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

115.311 (c)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

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

The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

AYFS PREA Organizational Chart (updated 01-27-2022)

CL-25 Sexually Abusive Behavior Prevention and Intervention (PREA)

LDP 2022 Org chart

OP-20 South Mountain-Facility Response Plan (3-27-2019)

Sexually Abusive Behavior Prevention and Intervention Program (PREA) (updated 11-03-21)

Zero Tolerance Towards Sexual Abuse and Harassment (updated 08-04-2021)

115.311 (a): Abraxas Youth and Family Services AYFS is committed to a zero-tolerance standard for incidents of sexual abuse and sexual harassment. The agency has developed and implement policies to comply with PREA standards for Juvenile Facilities. The AYFS and other stakeholders associated with AYFS are committed to preventing, detecting, and responding to sexual abuse and sexual harassment. Everyone has the right to be free from sexual abuse, sexual harassment, neglect, and exploitation. This includes not being subjected to sexually assaultive, abusive, and/or harassing behavior from staff and other residents. AYFS policies establishes that all facilities, staff, residents, volunteers, contractors, or visitor are committed to a zero-tolerance standard for incidents of sexual abuse and sexual harassment. Residents with disabilities are afforded the same rights and will be provided access to interpreters, presented material to effectively communicate with those residents who have intellectual disabilities, limited reading skills, blind or have low vision. Residents will have access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. Interpreters will be provided through local community resources. Residents with disabilities have equal opportunity to participate in and benefit from all aspects Leadership Development Program (LDP) efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Abraxas Youth & Family Services was previously a part of The GEO Group, until it left GEO to become a non-profit. LDP is a 128-bed staff secure residential treatment facility which provides intensive treatment and support services for adjudicated male youths who have complex behavioral issues including sexual offenses and short-term structured residential care for both male and female residents that is separate from the intensive treatment program. In interviews with clinical staff, the center has not only embraced PREA mandates but have adapted PREA standards and culture into the program model.

115.311 (b): Abraxas Youth & Family Services employees a PREA Coordinator that oversees the efforts to comply with the PREA standards in all Juvenile Facilities under the umbrellas of Abraxas Youth and Family Services. Abraxas Youth & Family Services appointed a PREA coordinator that reports to the President who have sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities. The PREA coordinator reports to ensures that all its facilities have a PREA Compliance Manager with sufficient time and authority to coordinate the facilities PREA efforts.

115.311 (c): The facility has a PREA compliance manager that oversee the implementation of all PREA standards and ensures compliance with PREA standards. In interview he indicated he had the time to conducts his duties.

Compliance was determined by review of the Abraxas Youth & Family Services organizational chart and interviews with the 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.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

The facility does not contract with other facilities to provide supervision of residents.

Standard 115.313: Supervision and monitoring

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

115.313 (a)

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

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

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

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

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

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

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

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

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

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

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

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

115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? ☒ Yes ☐ No
- In circumstances where the staffing plan is not complied with, does the facility document all deviations from the plan? (N/A if no deviations from staffing plan.) ☐ Yes ☐ No ☒ NA

115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.)
☒ Yes ☐ No ☐ NA
- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) ☒ Yes ☐ No ☐ NA
- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) ☒ Yes ☐ No ☐ NA
- Does the facility ensure only security staff are included when calculating these ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) ☒ Yes ☐ No ☐ NA
- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? ☒ Yes ☐ No

115.313 (d)

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

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

115.313 (e)

- Has the facility implemented a Policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA
- Is this Policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA
- Does the facility have a Policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

Staff to youth ratio docs
 Staffing Plan
 Unannounced Tours
 LDP Staffing Plan 2022
 LDP Annual PREA Facility Assessment 2021 - Final (11-23-2021)
 EOC-11 Security
 PREA Round documentation
 Resident Daily Rosters

115.313 (a): Each year the agency reviews staffing and the need for cameras, staffing or rearranging the staffing plan to meet the required staff in order to maintain a safe and secure operation. Their

staffing plan's annual reviews conducted in 2021 were found to be in compliance with this standard. The staffing plan included: (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 did not report deviations from the staffing plan during the past 12 months. The staff to-youth ratios of a minimum of 1: 6 during the resident waking and minimum of 1:12 during sleeping hours for the intensive therapeutic program and 1:8 and 1:16 for the residential shelter program is always maintained, the facility has a mechanism in place for call outs and staff volunteer to stay over if needed. LDP utilizes staff monitoring to protect the residents from sexual abuse and harassment. Based on conversations with the PREA coordinator and facility administrator it was obvious that the facilities review all areas of the center for additional staffing and resident movement in order to meet the requirement of this standard. The direct care staff were noted to be located throughout the center during the tour or review of cameras monitoring. Random interviewed direct care confirmed that they are assigned based on activities at each unit which will impact the staffing plan. The random staff stated that the center does not count control operators toward meeting this requirement. The facility administrator provided a daily roster that indicates the staffing utilized during the prior 24 hours. All residents are assigned a therapist that provides group and individual counseling programs. During these sessions, residents are supervised by cameras or out of sound supervision by youth workers.

115.313 (b): The facility administrator provided a daily roster that indicates the staffing utilized during the prior 24 hours. During the pandemic the center had to reduce the resident capacity in order to provide staff that ensured compliance with the staff to resident ratios. The center also provided overtime pay and utilized management staff to meet the mandates of the staff to resident ratios. The auditor reviewed the staffing schedules for the past 90 days and found that the facility was providing overtime pay for staff on a routing basis. However, there were no instances when the mandatory staff requirement was not met.

115.313 (c): EOC-11 Security EOC-11 Security mandates that the staffing plan will be reviewed and approved by the PREA coordinator at least yearly. The facility staffing plan for 2022 was submitted prior to January 2022. Abraxas Youth & Family Services conducts an extensive review of all areas of private facilities and assesses the need for additional cameras, staffing programming, and overall operation of the facility.

115.313 (e): The Facility administrator and PREA compliance manager conduct and document unannounced rounds on all shifts and all areas of the facility to monitor and deter staff sexual abuse and harassment. Each shift supervisor makes rounds several times during each shift. It is the policy of LDP that staff are not to inform other staff when the shift supervisor, facility manager or regional administrators are making rounds. During the tour the auditor reviewed the logbooks in all housing units and noted that the shift supervisor, and facility administrator had signed to logbook a minimum

of one a day for the last three-week excluding weekends. Shift supervisor had signed the logbooks on each day including weekends.

Compliance was determined by review of policies, documentation and interview with staff confirm compliance with this standard. Staff could not meet with the auditor until they were properly relieved to ensure the facility always had the appropriate ratio of clients to staff members.

Standard 115.315: Limits to cross-gender viewing and searches

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

115.315 (a)

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

115.315 (b)

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

115.315 (c)

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

115.315 (d)

- Does the facility have policies that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No
- Does the facility have procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No
- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? ☒ Yes ☐ No
- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units) ☒ Yes ☐ No ☐ NA

115.315 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? ☒ Yes ☐ No
- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? ☒ Yes ☐ No

115.315 (f)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

CL-12 Resident Rights
EOC-11 Security
OP-12 Resident Screening and Search Procedures
Training Forms 1
Training Forms 2
Training File Reviews
PAQ

115.315 (a): Based on interviews with staff and residents there have been no cross-gender pat down searches in the last 12 months. An intake staff member indicated that upon admission to LDP, the resident is then taken to a private area by two staff of the same gender as the resident. The resident is asked to remove their outer garments, but not to remove their undergarments. The staff member then confirms that there is no contraband visually and identifies any tattoos, scars, bruises or other marks. All marks are documented on the Body Observation Form. Abraxas search policy prohibit any touching of a resident's body during a search.

115.315 (b): OP-12 Resident Screening and Search Procedures mandates the facility always refrain from conducting any cross-gender pat down except in exigent circumstances. All staff interviewed indicated they have never conducted a cross-gender search. All resident interviewed stated they had never been searched by a staff of the other gender.

115.315 (c): The facility did not have any transgender or intersex resident at the facility. All cross-gender searches are documented. According to the PAQ there were no cross-gender searches during the last 12 months.

115.315 (d): A tour of the center found that all areas that are utilized for housing residents have necessary barriers to allow resident to shower without being viewed by person of the opposite gender and privacy from other residents during the showering process. All resident stated they are allowed to change clothes and shower in private. A review of the cameras noted there were no cameras that provided views of the shower or toilet areas in any of the units. All staff of the other gender always announce their presence when entering a housing unit. There are reminders poster placed at the entrance of each housing unit. Staff and resident confirm that staff announce their presence and will knock on the door prior to looking in during counts.

115.315 (e): Agency policy prohibits searching or physically examining a transgender or intersex youth for the sole purpose of determining the youth's genital status. Policy mandates that if a resident's genital status is unknown, 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. Prior to arriving, residents are screened by an assessment center and will be provided with mental health, medical documentation. The Clinical Supervisor stated she would meet with the resident and take into consideration of his/her sexual orientation and treat them accordingly.

115.315 (f): A review of the staff training plan includes intervention techniques and standards required to be utilized prior to conducting any searches. Interview with random staff confirmed they had received training on intervention techniques. This training included conducting cross gender searches in a professional and respectful manner.

Compliance was determined by review of policies, watching the cross-gender video, and interview with resident and staff.

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*)

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The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

PA Abraxas Zero Tolerance Poster – Spanish

PA Abraxas Zero Tolerance Poster - English (updated 08-26-2021) (1)

Language Line Solutions Quick Guide - AYC 791008 (1)

115.333 Youth Safety Guide - PA - Spanish (updated July 20, 2021)

115.333 Youth Safety Guide - PA - English (updated July 20, 2021)

AYFS Policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program (PREA)

115.316 (a)(c): AYFS Policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program mandates that facilities will ensure that Residents with disabilities (e.g., those who are deaf, hard of hearing, blind, have low vision, intellectual, psychiatric or speech disabilities) have an equal opportunity to participate in or benefit from the Company's efforts to prevent, detect, and respond to Sexual Abuse and Sexual Harassment. Such steps will 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.

AYFS will ensure that all of its Facilities provide written materials to every resident in formats or through methods that ensure effective communication with Residents with disabilities, including those who have intellectual disabilities, limited reading skills or who are blind or have low vision. Facilities will not rely on 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 Section K2, or the investigation of the resident's allegations. Any use of these interpreters under these type circumstances will be justified and fully documented in the written investigative report.

Residents receive information explaining the agency's zero tolerance Policy in an age-appropriate fashion including how to report incidents or suspicions of sexual abuse or sexual harassment in the appropriate manner, taking into consideration age, disabilities, sexual orientation, and language. The youth safety manual was reviewed and is a model to provide information that is child friendly.

The comprehensive education is accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled as well as to the residents who have limited reading skills. If the youth report a deficiency or the staff are aware of a deficiency in any of these areas, they will report to the supervisor the need for an additional resource. The supervisor will notify the facility administrator who will contact the appropriate community resource services. Arrangements will be made for an interpreter who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, when necessary. In all circumstances this center will not rely on resident interpreters.

115.316 (b): The facility has a contract for language services. The facility also has access to language sign language staff. Staff would read all information required for an orientation into the facility and the comprehensive PREA training for residents that can't read.

Compliance was determined by review of policy, language line contract, and interviews with clinical supervisor director, education staff, facility administrator and PREA compliance manager.

Standard 115.317: Hiring and promotion decisions

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

115.317 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

115.317 (b)

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

115.317 (c)

- Before hiring new employees, who may have contact with residents, does the agency perform a criminal background records check? ☒ Yes ☐ No
- Before hiring new employees, who may have contact with residents, does the agency consult any child abuse registry maintained by the State or locality in which the employee would work? ☒ Yes ☐ No
- Before hiring new employees who may have contact with residents, does the agency, consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? ☒ Yes ☐ No

115.317 (d)

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

115.317 (e)

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

115.317 (f)

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

115.317 (g)

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

115.317 (h)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
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☐ **Does Not Meet Standard** (Requires Corrective Action)

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The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

AYFS Policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program
10 Personnel Files
PREA questionnaire

115.317 (a): AYFS shall not hire or promote anyone who may have contact with youth and shall not enlist the services of any contractor who may have contact with youth, 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 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.
4. AYFS shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with youth.
6. AYFS shall ensure that a criminal background records check has been completed, and consult applicable child abuse registries, before enlisting the services of any contractor who may have unsupervised contact with youth.

During initial interviews, prospective employees, interns, and volunteers shall be informed of the background check procedure. AYFS shall require the following background checks on all DJJ staff, volunteers, interns, and contractors and any applicant that is being considered for employment or promotion with DJJ:

1. Criminal background or records check.
2. Sexual offender registry check; and
3. Child abuse and neglect registry check.

115.317 (b): The Agency Policy states any incidents of sexual harassment by a staff member will be taken into consideration if the staff member is eligible for promotion. Prior to a promotion the facility will conduct a promotion board. Prior to meeting with the board, the applicant completes a questionnaire that includes all areas of 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. 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 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.

115.317 (c): During initial interviews, prospective employees, interns, and volunteers shall be informed of the background check procedure. AYFS shall require the following background checks on all DJJ staff, volunteers, interns, and contractors and any applicant that is being considered for employment or promotion with DJJ:

1. Criminal background or records check.
2. Sexual offender registry check; and
3. Child abuse and neglect registry check.

The human resources staff indicated in interviewed and confirmed by reviewing personnel files that she conducts a reference check on all prospective employees. This check include any past history of sexual abuse, sexual harassment including sexual harassment toward other staff.

115.317 (d): AYFS shall ensure that a criminal background records check has been completed, and consult applicable child abuse registries, before enlisting the services of any contractor who may have unsupervised contact with youth.

115.317 (e): AYFS shall conduct background checks on all staff, volunteers, interns, and contractors every five (5) years, or sooner. This was confirmed by reviewing background check for staff with 5 year or more tenure at the facility.

115.317 (f): The agency asks applicants about previous misconduct described in paragraph (a) of this section in written applications or during interviews for hiring or promotions. The facility does a yearly staff appraisal and sexual abuse, or sexual harassment is part of that appraisal.

115.317 (g): AYFS Policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program mandates that employees and volunteers will report any arrest, which include any notice to appear in court for a criminal Charge, to their immediate supervisor within 24 hours of the arrest or receipt of the notice to appear. Failure to report may result in disciplinary action up to and including termination.

Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. FOP 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 Facility Administrator, the evidence shows the facility follows this provision of the standard.

115.317 (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 Facility Administrator confirmed the facility would provide this information if requested to do so. Policy and FOP states the information would be provided when requested unless it is prohibited by law to provide the information.

Compliance with the standard was determined by review of policies, personnel files, and interviews with Personnel supervisor, agency head, PREA coordinator and facility administrator.

Standard 115.318: Upgrades to facilities and technologies

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

115.318 (a)

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

115.318 (b)

- If the agency installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology, did the agency consider how such technology may enhance the agency's ability to protect residents from sexual abuse? (N/A if agency/facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit, whichever is later.)
☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The facility has not made any substantial upgrades to the camera system since 2016 when the facility had made some upgrades based on the 2016 PREA audit. This information was noted on the last PREA audit. During the on-site tour, the video surveillance system was observed, and all cameras were pointed out by staff. The video monitoring system was assessed during the annual review of the staffing plan. The interview with the Facility Administrator and the Pre-Audit Questionnaire confirmed compliance with this standard.

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

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

115.321 (a)

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

115.321 (b)

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

115.321 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? ☒ Yes ☐ No
- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No
- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? ☒ Yes ☐ No
- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

115.321 (d)

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

115.321 (e)

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

115.321 (f)

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

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

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

Auditor Overall Compliance Determination

- ☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

115.321 Evidence Protocol and Forensic Medical Examination

PA State Police MOU

AYFS Policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program

Investigating PREA Allegations (updated 11-03-2021)

Investigative protocol

PREA-Advocacy poster

MOU agreement with Women in Need (WIN)

115.321 (a): Investigating PREA Allegations policy establishes that the evidence protocol to be utilized in sexual assault cases involving residents to be developmentally appropriate and to mirror the U.S. Department of Justice Office of Violence Against Women's "A National Protocol for Sexual Assault Medical Forensic Examinations for Adults/Adolescents." A victim of sexual abuse at LDP will be transported to Chambersburg Hospital (Summit Health System) where the hospital shall coordinate with Women in Need (WIN) to provide a Sexual Assault Forensic Examiner/Sexual Assault Nurse Examiner (SAFE/SANE) forensic examination, if warranted. LDP shall also contact WIN to provide a victim advocate accompany the victim to the hospital and support the victim. In the absence of a WIN advocate, LDP shall provide a trained staff advocate to accompany the victim to the hospital.

115.321 (b): and (F): 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. Policy provides for the uniform Protocols to be followed. The Protocol is outlined regarding appropriateness for youth and adults. The agency-based investigators conduct administrative investigations, and the PA State Police investigate sexual abuse allegations that are criminal in nature. Staff interviews confirmed an understanding of the facility's protocol for obtaining usable physical evidence if a resident alleges sexual abuse and knowledge of the entities responsible for conducting investigations.

115.321 (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. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs. The facility does have a MOU with WIN. The MOU with WIN states: "WIN is open to receiving referrals through a 24-hour hotline to provide a Sexual Assault Nurse Examiner (SANE) and victim advocacy services during an investigation. WIN can also provide information and referrals for further services to assist a sexual assault victim and his/her family. The need for SANE or Sexual Assault Forensic Examiner (SAFE) for an investigation will be referred to the PSP and Summit Health, the operator of the Chambersburg and Waynesboro Hospitals."

115.321 (d): The facility does have a MOU with WIN for victim advocacy services. This MOU includes advocacy services and emotional support services. The Victim's center director was contacted and provided a review of the program and services available to residents at both Abraxas Youth and Family Services at no cost to the resident. She verbally provided qualification of advocacy staff at the program and the services they provide to residents. The medical center staff interviewed by telephone verified that the hospital had SANE staff on duty and had a working relationship with WIN. A qualified victim advocate would accompany a resident for a SANEs and during the law enforcement investigations. The advocate program would continue to offer emotional support, crisis intervention and referrals. The center has full time clinical therapist that would also provide crisis intervention as requested by the victim and as part of the resident treatment plan.

115.321 (g) The facility has a MOU with a Rape Crisis center. Compliance was determined through the review of MOU with WIN and interviews with facility investigator. Reviews of policies also contributed to the finding of compliance. Interviews with Mental Health Provider, Medical Administrator, the Victim's center staff and with investigator also provided compliance with this standard.

Standard 115.322: Policies to ensure referrals of allegations for investigations

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

115.322 (a)

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

115.322 (b)

- Does the agency have a Policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No
- Has the agency published such Policy on its website or, if it does not have one, made the Policy available through other means? ☒ Yes ☐ No

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

115.322 (c)

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

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

Policy 5.3 Investigating PREA Allegations
PAQ

115.322 (a & b) Policy 5.3 Investigating PREA Allegations requires allegations of sexual abuse or sexual harassment be referred to an agency with the legal authority to conduct criminal investigations unless the allegation does not involve criminal behavior. There were three allegation of sexual abuse that were reported by residents in the last 12 months. All reports were forward to PSP for investigations. A review of AYFS website included how to report and statement that all allegations will be investigated and a PREA policy including Investigating PREA Allegations.

115.322 (c): Policy 5.3 Investigating PREA Allegations mandates that staff will secure the scene, not let the victim or predator change clothing, brush teeth, use the restroom or shower. The facility will assist the investigator in making available video and other material as requested. The PSP will report to the facility if the allegation is criminal in nature and facility trained investigator will conduct the investigation if the incident is not criminal in nature.

Compliance was verified by reviewing policies, procedures, agency website and interviews with agency designee, facility administrator, Investigator from OIG, staff, and residents.

TRAINING AND EDUCATION

Standard 115.331: Employee training

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

115.331 (a)

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

- Does the agency train all employees who may have contact with residents on how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities?
☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on relevant laws regarding the applicable age of consent? ☒ Yes ☐ No

115.331 (b)

- Is such training tailored to the unique needs and attributes of residents of juvenile facilities?
☒ Yes ☐ No
- Is such training tailored to the gender of the residents at the employee's facility? ☒ Yes ☐ No
- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No

115.331 (c)

- Have all current employees who may have contact with residents received such training?
☒ Yes ☐ No
- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No
- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

115.331 (d)

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

Auditor Overall Compliance Determination

- ☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

AYFS PREA Initial Training - Final (updated 11-03-2021)

PREA Initial Training Quiz - Answer Key (updated 11-03-2021)

PREA Initial Training Quiz (updated 11-03-2021)

PREA Staff Training Sign In Sheets

Training Forms 1

Training Forms 2

115.331 (a): The agency 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 are also conducted and is documented. The direct care staff interviewed and the PREA Compliance Manager reported the training is provided as required. All direct care staff members interviewed, and document review verified the general topics below were included in the training:

1. The center Zero Tolerance Policy for sexual abuse and sexual harassment.
2. How to fulfill their responsibilities under the center sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures.
3. Residents' right to be free from sexual abuse and sexual harassment.
4. The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment.
5. The dynamics of sexual abuse and sexual harassment juvenile facilities.
6. The common reactions of juvenile victims of sexual abuse and sexual harassment.
7. 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.
8. How to avoid inappropriate relationships with residents.
9. How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents.
10. How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities; and
11. Relevant laws regarding the applicable age of consent.

115.331 (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 female and male residents to a facility that houses only female residents, or vice versa. The facility houses female, and males and the training consider 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. Part of the staff training is a quiz that includes questions about male, female and targeted populations,

115.331 (c): The agency provides each employee with refresher each year to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures. In recent years the yearly in services added a video on conducting cross gender or persons frisk searches (pat down). All staff are required to complete this training. Training roster and training records were reviewed and documented this training. The agency 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.

115.331 (d): The agency document training, 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. 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 direct care staff interviewed and the PREA Compliance Manager reported the training is provided as required. All direct care staff members interviewed, and document review verified the general topics below were included in the training: At the facility, it was evident through documentation, interviews, and observation of the day-to-day operations the staff is trained continually about the PREA standards during shift briefings, monthly staff meetings, and the completion of various on-line and instructor led trainings.

Compliance was determined by reviewing preservice and in service training curriculum and a review of the training records of 10 staff including medical, mental health, direct care, facility administrator indicated staff have received the training. An interview with random staff also confirmed that they received the training and refresher training as mandated by policy.

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

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The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

Volunteer and Contractor Training

Contractor Training

AYFS PREA Training for Volunteers and Contractors 2021 (updated 10-20-2021)

115.332 (a): AYFS PREA Training for Volunteers and Contractors provides for all aspects of this standard. Training includes AYFS PREA policies provide written guidelines to ensure:

- There is a safe, secure environment for staff, volunteers, contractors and residents.
- Each facility has a "zero tolerance" philosophy towards sexually abusive behavior. ALL Volunteers and Contractors are responsible for understanding and preventing sexually abusive behavior.

115.332 (b): 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.

115.332 (c): The agency shall maintain documentation confirming that volunteers and contractors understand the training they have received. The PREA Notification document contains 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.

During the last year, 7 contractors or volunteers have received the Volunteer and Contractor training. At the time of the audit the facility did not have any volunteer and only contractors for vending machine, and medical specialist such as physician. The facility administrator indicated the facility is going to start the training, background checks and contracting and volunteer program in the near future. A review of the training curriculum and interviews with personnel staff and PREA compliance manager confirm that the facility has all of the required policies, procedures, training and staff to implement a volunteer and contract program.

Standard 115.333: Resident education

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

115.333 (a)

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

115.333 (b)

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

115.333 (c)

- Have all residents received the comprehensive education referenced in 115.333(b)? ☒ Yes ☐ No
- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility? ☒ Yes ☐ No

115.333 (d)

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

115.333 (e)

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

115.333 (f)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

AYFS Policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program
 115.333 Youth Safety Guide - PA - English (updated July 20, 2021)
 115.333 Youth Safety Guide - PA - Spanish (updated July 20, 2021)

115.333 (a): 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. This information is provided by the staff that conduct the intake with resident. It is usually a case manager; however, it can be a therapist if a case manager is not available.

115.333 (b): Also during the intake, staff go over the Youth Guide, discuss the purpose of the guide provides question and answers to the comprehensive education about PREA and have resident sign and acknowledge form stated they have reviewed the training and understand how to report allegation of sexual abuse or sexual harassment, their rights to be free from sexual abuse or sexual harassment and that the center has a zero tolerance for sexual abuse or sexual harassment. Also, during the comprehensive education program, resident receive a resident handbook specific to the program they are being assigned which includes additional PREA information. Within three weeks of arriving at the center the center clinical staff will meet with the resident and discuss their safety plan and go over the youth guide again with the residents. In reviewing the training and the follow up training and interviewing staff and resident, the auditor began to understand that PREA is not a mandate but has been incorporated into the center's therapeutic community as a culture of expected norms for all staff and residents.

115.333 (c): AYFS Policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program requires that residents receive such education upon arrival or transfer at the facility and shall receive education upon transfer to a different AFFS center to the extent that the policies and procedures of the resident's new facility differ from those of the previous center.

115.333 (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. Documentation was reviewed of a contracting service for language lines. Posted PREA information is in English and Spanish accessible to residents, staff, contractors, volunteers, and visitors. Staff interviews confirmed residents are not used as translators or readers for other residents. The facility staff indicated that the clinical supervisor, medical staff, education lead teacher and operations manager would work with the community resources to provide education to residents regardless of his limitations or disabilities.

115.333 (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 residents were aware of PREA information, including their rights regarding PREA, how to report allegations and that they would not be punished

for reporting allegations of sexual abuse or sexual harassment. The Intake staff was interviewed regarding PREA education for residents. Staff ensures residents' receipt of the information, including the resident signing the acknowledgement form. A review of ten resident files confirmed they acknowledged the received a PREA orientation during intake and a comprehensive training within 10 days of arrival at the facility.

115.333 (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, safety guide or other written formats. The PREA education materials provide residents information on how to report allegations of sexual harassment and sexual abuse. A safety guide is provided to each resident to eliminate incidents of sexual abuse and sexual harassment. The guide 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 or telling a family. There were PREA educational documentation noted throughout the facility including the lobby, visitation and living units. When asked, each resident was able to tell me where their guide and handbook was and offered to bring it to me to see. Several stated they have notes from staff interviews in their guides.

Compliance was determined by review of the agency policies, training curriculum, poster, and resident files and by interviews with staff and resident.

Standard 115.334: Specialized training: Investigations

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

115.334 (a)

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

115.334 (b)

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

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

115.334 (c)

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

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

Specialized Investigator Certificate

Training Curriculum

PREA Annual Training

115.334 (a): The Policy has a MOU with Pa. State Police for criminal investigations, The MOU provides for the investigators to be trained on investigating sexual abuse in a juvenile confinement center. The center has 5 staff that have received training on conducting sexual abuse investigation in a confinement center.

115.334 (b): 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.

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 staff received training while the center was operated by GEO and the training was provided by the GEO Investigation Training division. A copy of the training curriculum is accessible to the auditor and was reviewed for compliance with this standard.

115.334 (c): The center provided certifications from all staff that have received the specialized training. The auditor requested and received the acknowledgement that the facility investigator received annual PREA refresher training.

Compliance was determined by review of the training curriculum in past audits, interviews with two investigators, PREA coordinator and the facility administrator.

Standard 115.335: Specialized training: Medical and mental health care

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

115.335 (a)

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

115.335 (b)

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

115.335 (c)

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

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
☒ Yes ☐ No ☐ NA
- Do medical and mental health care practitioners contracted by or volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

AYFS Policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program
Abraxas Youth and Family Services Specialized Medical and Mental Health Training
Sign In Roster

115.335 (a): AYFS Policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program provide medical and mental health staff members receive the regular PREA training. and the specialized training available developed by Abraxas Youth & Family Services. In addition to the Zero Tolerance policy , all full- and part-time medical and mental health care practitioners will be trained in the following: 1. How to detect and assess signs of sexual abuse and sexual harassment. 2. How to preserve physical evidence of sexual abuse. 3. How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment. 4. How and to whom to report allegations or suspicions

of sexual abuse and sexual harassment. 5. Medical and mental health practitioners are required by mandatory reporting laws to report sexual abuse. 6. Medical and mental health practitioners shall inform residents at the initiation of services of their duty to report and the limitations of confidentiality regarding sexual abuse.

115.335 (b): Forensic medical examinations are not conducted by the facility medical staff or mental health staff.

115.335 (c): The facility provided sign in sheets indicated that medical and mental health staff had attended medical specialized training. The agency utilizes a training program titled Abraxas Youth & Family Services Specialized Medical and Mental Health Training. Participants sign in to acknowledge they have received this training.

115.335 (d): The mental health and medical staff completed the general and refresher training provided for all staff members.

A review of the training curriculum, sign in rosters and interview with medical and mental health staff confirmed that the staff have received specialized training and generalized training as required by standards and have additional training that exceeds the expectations of the standards.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

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

115.341 (a):

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

115.341 (b)

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

115.341 (c)

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

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (3) Current charges and offense history? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (4) Age? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (5) Level of emotional and cognitive development? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (6) Physical size and stature? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (7) Mental illness or mental disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (8) Intellectual or developmental disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (9) Physical disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (10) The residents' own perception of vulnerability? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? ☒ Yes ☐ No

115.341 (d)

- Is this information ascertained through conversations with the resident during the intake process and medical mental health screenings? ☒ Yes ☐ No
- Is this information ascertained during classification assessments? ☒ Yes ☐ No
- Is this information ascertained by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files? ☒ Yes ☐ No

115.341 (e)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive

information is not exploited to the resident's detriment by staff or other residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

AYFS Policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program (PREA)

AYFS Policy CL-06 Admissions Record and Assessment Requirements

Initial Assessments

Intake PREA Assessments – LBTGQ

LDP Room Matrix

Reassessments – LBGTO

Reassessments

115.341 (a) and (b): Upon admission, within 24 hours, all clients will be assessed using the Screening for the Risk of Victimization and Sexually Aggressive Behavior form. Clients will be re-assessed using the same form if relevant new information becomes available, an episode of victimization or sexually aggressive behavior occurs, or every six months. Information obtained during the assessment and from the client's referral information will be used to make appropriate housing decisions with the intent to reduce the risk of sexual abuse.

The staff member conducting the intake process will complete the screening using the Screening for the Risk of Victimization and Sexually Aggressive Behavior form and will immediately report any heightened risk to the supervisor on duty before making housing decisions. If the client has experienced prior sexual victimization or has previously perpetrated sexual abuse, (s)he will be offered a follow-up meeting with a medical or mental health practitioner within 14 days. If the resident declines the follow-up meeting, this should be documented on the Declined Follow-Up Meeting Form. Residents who are deemed Vulnerable to Victimization will receive a follow up assessment within 30 days using the Vulnerable to Victimization Reassessment Questionnaire.

All residents will be periodically reassessed using the Vulnerable to Victimization Reassessment Questionnaire. Residents placed on the Shelter and Detention units will be reassessed every 30 days and all other residents will be reassessed on a quarterly basis.

115.341 (c): Risk of Victimization and Sexually Aggressive Behavior screening include mental, physical, or developmental disabilities, age, physical build, prior incarcerations, criminal history (violent and non-violent), prior convictions for sex offenses against an adult or child, prior acts of sexual abuse, prior convictions for violent offenses, history of prior institutional violence or sexual abuse, prior sexual victimization, perception of vulnerability, and if the resident is or is perceived to be (LGBTQI) or gender nonconforming.

115.341 (d): AYFS Policy CL-06 mandates that all residents will be interviewed using an objective screening instrument for risk of victimization potential vulnerabilities or sexual abusiveness tendencies to act out with sexually aggressive predatory behavior within seventy-two (72) hours. Screening staff interviewed indicated staff review the residents court records, suicide screening reports, family information and any other documents that are provide to them at the time of intake. The screening staff utilizes the screening instrument during the initial intake process that includes and conversation with the resident in a private setting. The screening staff indicated they introduce the screening instrument to the resident by explaining the purpose of the questions and acknowledges to the residents that that the know they just had the same questions, but it is important in order to make sure they are safe and get the most out of the stay at the center. After the initial screening or prior to the screening the medical staff interviews the residents and conduct a medical screening. The nurse indicated she talks about sexual transmitted diseases and residents' perception of vulnerability. The clinical staff then interview all residents prior to determining which therapist is best suited to work with the resident and also reviews the Victimization and Sexually Aggressive Behavior screening and if they have history of victimization, the therapist utilizes this time to offer additional support and sets us a time to meet with the resident within 72 hours to interview them about victimization.

115.341 (e): Sensitive information obtained will not be exploited to the resident's detriment by staff or other residents. All staff will follow appropriate confidentiality when dealing with sensitive information. Information obtained will only be used to make housing, bed, program, and education assignments with the goal to keep all residents safe and free from sexual abuse and to reduce the risk of victimization.

Based on the review of the agency policy and procedures, observations and information obtained through staff and resident interviews, and review of 10 resident files, the facility has demonstrated exceed compliance with this standard.

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? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA
- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA
- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA
- Do residents in isolation receive daily visits from a medical or mental health care clinician? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA
- Do residents in isolation also have access to other programs and work opportunities to the extent possible? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

115.342 (c)

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

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

115.342 (d)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider, on a case-by-case basis, whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by Policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? ☒ Yes ☐ No
- When making housing or other 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 provision (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA
- If a resident is isolated pursuant to provision (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

115.342 (i):

- In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine

whether there is a continuing need for separation from the general population EVERY 30 DAYS? (N/A if the facility *never* places residents in isolation for any reason.)

☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

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The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

AYFS Policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program (PREA)
AYFS Policy CL-06 Admissions Record and Assessment Requirements
LDP Room Matrix

115.342 (a): All information obtained upon intake and periodically throughout the residents' confinement will be used to make housing, bed, program, and education assignments with the goal of keeping all residents safe and free from sexual abuse.

115.342 (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.

d. During any period of isolation, Facilities will not restrict Resident's daily large muscle exercise and any legally required educational programming or special education services.

e. Residents in isolation will receive daily visits from a medical or mental health care clinician. Residents will also have access to other programs and work opportunities to the extent possible.

f. If a Resident is isolated pursuant to paragraph (b) of this section, the Facility will clearly document the following:

- The basis for the Facility's concern for the Resident's safety; and
- The reason why no alternative means of separation can be arranged.

Every 30 days, the status of the Resident will be reviewed to determine whether there is a continuing need for separation from the general population.

115.342 (c): AYFS Policy CL-06 Admissions Record and Assessment Requirements mandates placement of Youth precludes lesbian, gay, bi-sexual, transgender, and intersex residents from being placed in a particular housing unit and states LGBTI identification or status is not an indicator of likelihood of being sexually abusive. Transgender or intersex resident's own view with respect to his/her safety will be given serious consideration. The PREA Compliance Manager's interview also verified compliance with this standard. During the site tour, there were no rooms observed to be reserved for transgender or intersex residents. A staff interview and observations revealed there is no special housing based on how a resident identifies.

115.342 (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 a special housing which was evident from staff interviews. There were no transgender or intersex residents in the facility during the onsite visit. The clinical director confirmed 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. In interviews with the administrative team, the staff indicated that a resident's sexual status was one of several considerations for housing and programming resident. Since it is a treatment program with groups of four to eight, the center stratifies the groups based on size, maturity, age and would also utilizes the resident preference, sexual orientation, and perception in placing youth with different therapist.

115.342 (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. This function would be done to review any threats to safety experienced by the resident and the Intake staff is aware of the requirement. The Clinical Director confirmed each transgender or intersex resident would be reassessed at least twice each year to review any threats to safety experienced by the resident by Policy, however in reality, residents are reassessed on an ongoing basis. Based on the review of the Pre-audit Questionnaire and interview with the Intake staff, the evidence shows the facility follows this provision of the standard.

115.342 (f): A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration. The resident's concern for his own safety is taken into account through the administration of the Vulnerability Assessment and this applies to every resident. The residents confirmed in the interviews, they are asked about their safety concerns. A review of the PREA Education & Screening Log demonstrated the additional documentation of the screening assessments and re-assessments completed for each resident. The staff interviews revealed staff members are aware of the Policy which requires the provision of the standard to be followed.

115.342 (g): Policy mandates that transgender and intersex residents shall be given the opportunity to shower separately from other residents. All staff interviewed were aware of that requirement, however most staff indicated that all residents are required to shower by themselves.

115.342 (h): If a resident is isolated pursuant to paragraph (b) of this section, the facility shall clearly document: (1) The basis for the facility's concern for the resident's safety; and (2) The reason why no alternative means of separation can be arranged. The policy states if a resident is isolated pursuant to part (B.2.) of this section, the facility shall document a. The basis for the facility's concern for the resident's safety; and b. The reason why no alternative means of separation can be arranged. No residents at risk of sexual victimization were placed in isolation in the 12 months preceding the audit. Interviews with the Facility Administrator and PREA Compliance Manager confirmed the facility has not used isolation for this purpose. The Isolation/separation would be documented according to the provisions of the Policy and standard.

115.342 (i): Policy mandate that every 30 days, the facility shall afford each resident described in paragraph (h) of this section a review to determine whether there is a continuing need for separation from the general population. The policy states every thirty (30) days, staff shall afford each resident described in provision (b) of this section a review to determine whether there is a continuing need for separation from the general population. No residents at risk of sexual victimization were placed in isolation in the 12 months preceding the audit. Interviews with the Facility Administrator and PREA Compliance Manager, PREA coordinator confirmed the facility has not used isolation for this purpose.

Based on review of the agency policy and interviews with agency director, PREA coordinator, PREA compliance manager, facility administrator, clinical director and random staff, the facility is in full compliance of this standard.

REPORTING

Standard 115.351: Resident reporting

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

115.351 (a)

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

115.351 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No

- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No
- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No
- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment? (N/A if the facility *never* houses residents detained solely for civil immigration purposes.) ☐ Yes ☐ No ☒ NA

115.351 (c)

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

115.351 (d)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

Youth Safety Guide - PA - English (updated July 20, 2021)

Youth Safety Guide - PA - Spanish (updated July 20, 2021)

PA Abraxas Zero Tolerance Poster - English (updated 08-26-2021) (1)
PA Abraxas Zero Tolerance Poster - Spanish (updated 08-26-2021) (1)
Shelter Resident Handbook
Spec TX unit Handbook Master Jan 2022
AYFS Website

115.351 (a) T The above policies, MOUs and External reporting mechanism identifies the multiple internal ways for residents to report sexual abuse and harassment incidents, retaliation, staff neglect or violation of responsibilities that may have contributed to such incidents. The department has provided a method for staff to privately report sexual abuse and sexual harassment of residents.

The youth Safety guide advises youth of the following ways to make a report of sexual abuse or sexual harassment.

Talk to or send a letter or note to any of the following:

- A staff member you trust
- Program Director
- Program Manager
- Treatment Supervisor
- Therapist/Counselor
- Nurse
- Life Skill Worker/Youth Development Specialist
- Your Probation or Parole Officer
- Your attorney or advocate
- Your parents or guardians
- Chaplains or ministers

You can also file a grievance

Each Abraxas facility has a confidential process to inform therapists/counselors that a youth needs to speak with them. All staff members know what to do if you have been harmed and how to help you become safe.

You can make a report by calling ChildLine at 1-800-932-0313. An investigator will take your confidential call and follow-up on your report.

115.351 (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 may call the ChildLine at 1-800-932-0313. Residents may request to use a telephone with some degree of privacy to call the hotline without having to obtain staff permission and that mandates staff not to question residents about the reason for the call. A resident can request writing materials to write and send a letter to one of these sources. Random residents interviewed were aware of the abuse hotline and were able to articulate how they could gain access. Signs are posted explaining how to report to the Child Lines. Direct care

staff revealed staff could use the ChildLine at 1-800-932-0313 to report allegations of abuse. The facility does not detain residents solely for civil immigration purposes.

115.351 (c): Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports. 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. All residents interviewed revealed they are familiar with the provisions of the standard. The resident interviews demonstrated their familiarity with the various ways they may report either in person, in writing, by phone, completing a PREA/grievance or Medical Request Form, or through a third-party. The residents were aware third-party reports could be made and that reports can be made anonymously. Staff members interviewed were aware of their duty to receive and document third-party reports.

115.351 (d): The facility provides residents with access to tools necessary to make a written report. Writing materials are readily available for residents to complete the accessible forms. Prior to the site visit pictures were sent to the Auditor showing the reporting forms such as PREA/Grievance forms and Medical Request Forms and the accessibility of writing utensils. During the site visit and while on the site review, the Auditor observed the accessibility of writing utensils to the residents. Staff may privately report sexual abuse and sexual harassment of residents to their local law enforcement, state reporting agency, facility administrator or the PREA compliance manager. Staff must report sexual abuse and sexual harassment immediately to the Facility Administrator and must immediately notify the ChildLine. Staff and Facility Administrator confirmed that staff may report directly to the facility administrator, and he will coordinate with the staff to call the Child Line, PA licensing agency, PREA coordinator, PSP, contracting agency, and legal guardian.

Compliance was determined by review of posters, policy, and interview with staff, and residents.

Standard 115.352: Exhaustion of administrative remedies

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

115.352 (a)

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

115.352 (b)

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

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

115.352 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA
- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA
- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

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

115.352 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA
- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA
- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA
- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA
- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA
- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA
- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (g)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

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

Instructions for Overall Compliance Determination Narrative

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

The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

LDP Policy CL-12 Resident Rights
LDP Policy CL-20 Resident Grievance Procedures (LDP)
Resident Handbook
Posters
Youth Safety Guide
PAQ

115.252 (a): 115.252 (a): LDP Policy CL-20 Resident Grievance Procedures provides a procedure for residents to submit grievances regarding sexual abuse and the agency has procedures for dealing with these grievances. Instructions on how to file grievances are provided to residents on PREA Education Manual for Residents and PREA posters.

115.252 (b): There is no time limit when a resident can submit a grievance regarding sexual abuse. LDP does not impose a time limit to any portion of a grievance that does not allege an incident of sexual abuse. Residents are not required to use any informal grievance process or attempt to resolve with staff an alleged incident of sexual abuse. Agency policy does not restrict Abraxas Youth and Family Services the ability to defend against a lawsuit filed by an inmate on the ground that the applicable statute of limitations has expired. The PREA Compliance Manager receives all copies of grievances related to sexual abuse or sexual harassment for monitoring purposes. In interview with the PREA Compliance Manager and information provided on the PreAudit Questionnaire, in the past 12 months there were no grievances filed alleging sexual abuse.

115.252 (c): Based on facility policies, residents have a right to submit grievances alleging sexual abuse to someone other than the staff member who is the subject of the complaint and the grievance will not be referred to the subject of the complaint. Residents may submit grievances to the Facility Director or PREA Coordinator. If a third-party files a grievance on a resident's behalf, the alleged victim must agree to have the grievance filed on his behalf.

115.252 (d): A final decision shall be issued on the merits of any portion of the grievance alleging sexual abuse within 90 days of the initial filing of the grievance. Computation of the 90-day time period shall not include time consumed by individuals in the facility in preparing any administrative appeal. Facilities may claim an extension of time to respond (for good cause), of up to 70 days and shall notify

the individual of the extension in writing. At any level of the administrative process, including the final level, if the individual does not receive a response within the time allotted for reply, including any properly noticed extension, the individual may consider the absence of the response to be a denial at the first level.

115.252 (e): Third parties such as fellow residents, family members, attorneys or outside advocates may assist residents in filing requests for administrative remedies relating to allegations of sexual abuse and may file on behalf of residents. The alleged victim must agree to have the request filed on his or her behalf; however, he/she is not required to personally pursue any subsequent steps in the administrative remedy process. If the resident declines to have the request processed on his or her behalf, the agency shall document the resident's decision. In interview with the PREA Compliance Manager and on information provided in the Pre-Audit Questionnaire, in the past 12 months, there were no grievances filed by a third party.

115.252 (f): Residents may file an emergency grievance if he/she is subject to substantial risk of imminent sexual abuse. After receiving an emergency grievance of this nature, the Facility Director designee will ensure that immediate corrective action is taken to protect the alleged victim. An initial response to the emergency grievance to the individual is required within 48 hours and a final decision will be provided within five calendar days. In interview with the PREA Compliance Manager and on information provided on the Pre-Audit Questionnaire, in the past 12 months, there were no emergency grievances alleging sexual abuse filed.

115.252 (g): A resident can be disciplined for filing a grievance related to alleged sexual abuse if it is determined that the inmate filed the grievance in bad faith. There has been no disciplinary action due to filing a grievance in bad faith.

Staff and residents interviewed were aware of the grievance system and how to access forms, pencils and were aware of the location of the grievance box.

Compliance was determined by review of the policies, interview with the grievance staff, PREA compliance managers, residents, and presence of grievance provides a procedure for residents to submit grievances regarding sexual abuse and the agency has procedures for dealing with these grievances. Instructions on how to file grievances are provided to residents in the Youth Safety Guide and resident's handbook and PREA posters.

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

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

115.353 (a)

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

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

- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? (N/A if the facility *never* has persons detained solely for civil immigration purposes.) ☐ Yes ☐ No ☒ NA
- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.353 (b)

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

115.353 (c)

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

115.353 (d)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

AYFS Policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program (PREA)

Youth Safety Guide - PA - English (updated July 20, 2021)

Youth Safety Guide - PA - Spanish (updated July 20, 2021)

PA Abraxas Zero Tolerance Poster - English (updated 08-26-2021) (1)

PA Abraxas Zero Tolerance Poster – Spanish

PA State Police MOU

WIN MOU

115.353 (a): AYFS Policy 5.5 mandates 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. LDP ensures residents are provided access to outside confidential support services. The facility has established an MOU with WIN which provide emotional support, counselling; follow-up support; and referral for treatment after release or transfer to another facility. The staff indicated that besides providing victim advocacy, they provide a telephone number that will allow the resident to talk to a trained counselor for emotional support. They would also make arrangements to visit with the victim or have the victim brought to them or another location if allowed by the facility.

115.353 (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 statement specific to the review of the reporting and advocacy services contains information regarding the advocacy services to be provided by The Victim Service Center. When contacted by phone the center's staff explained they always tell the caller that the telephone calls or confidential however, they have a responsibility to report allegation of child abuse or child neglect.

115.353 (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. The FOP states the resident may use the phone, located on each living unit, and push the appropriate number to gain access and speak with a victim advocate. The agency is identified on the signage along with directions for reporting

allegations or requesting advocacy services. The Facility Administrator confirmed the availability and accessibility of outside confidential support services to residents.

115.353 (d): The facility shall also provide residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians. The interview's confirmed residents have access to attorneys and court workers and reasonable access to their parents/legal guardians. The site tour revealed areas where residents could meet privately with a legal representative and the visitation area for visits with family members. All residents interviewed stated family could visit and they provided the days and times of visitation and for phone calls. Residents interviewed confirmed the facility would allow them to see or talk with their lawyer, another lawyer or a court representative privately. Residents interviewed confirmed the facility would allow them to see and talk with their parents or someone else, such as a legal guardian. Visitors to the facility are informed of PREA. The Facility Administrator confirmed the facility provides residents with reasonable and confidential access to their attorneys or court representatives and reasonable access to parents or legal.

Compliance was determined by review of center visitation rules, policies, and memorandums, poster located throughout the facility and interview with Staff of the WIN, facility administrator and random staff and residents.

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

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The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

Shelter Resident Handbook

Spec TX unit Handbook Master Jan 2022

Third Party Poster - English (updated 08-26-2021)

Third Party Poster - Spanish (updated 08-26-2021)

115.354 (a): PREA Reporting Posters and Abraxas website meet the requirements of this standard. PREA Reporting Posters are visible in the visitation room, lobby and is found in the client handbook. AYFS provides information on ways for third party reporting including anonymous reporting. Poster include anyone needed to report abuse/ sexual harassment or to report an allegation of Sexual Abuse/ Sexual Harassment on behalf of an individual who is or was housed in any AYFS facility or program, may contact the Facility Administrator's Office in the facility where the alleged incident occurred or where the individual is housed. Reports can be made over the phone, in person, in writing or anonymously if desired. Persons can also contact the Corporate PREA Office.

Compliance was confirmed by reviewing policies, posters and AYFS Website and by interviews with residents and PCM.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

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

115.361 (a)

- Does the agency require all staff to report immediately and according to agency Policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No
- Does the agency require all staff to report immediately and according to agency Policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No
- Does the agency require all staff to report immediately and according to agency Policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

115.361 (b)

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

115.361 (c)

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

115.361 (d)

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

115.361 (e)

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office? ☒ Yes ☐ No
- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified? ☒ Yes ☐ No
- If an alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? ☒ Yes ☐ No
- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation? ☒ Yes ☐ No

115.361 (f)

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

Auditor Overall Compliance Determination

- ☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

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

Instructions for Overall Compliance Determination Narrative

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The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

AYFS policy OP-20 Facility PREA Response Plan Following Resident Report

1. **115.361 (a) (b):** During the intake process, residents are informed of the facility's duty to report and the limitations of confidentiality.
2. Employees, Contractors, and Volunteers are required to immediately report any of the following:
 - a. Knowledge, suspicion, or information regarding an incident of sexual abuse, sexual harassment, or exploitation that occurred in the facility.
 - b. Retaliation against residents or employees who reported such an incident.
 - c. Any employee, contractor, or volunteer neglect or violation of responsibilities that may have contributed to an incident or retaliation.
3. Any employee, contractor, or volunteer suspecting abuse, neglect, or exploitation must immediately report the incident to Pennsylvania ChildLine
4. Following a report, the employee, volunteer, or contractor suspecting sexual abuse or sexual harassment will immediately notify the PREA Compliance Manager or Administrator On-Duty.
5. If an alleged crime occurs against a child or adolescent, the PREA Compliance Manager, Administrator On-Duty, or designee shall immediately notify law enforcement authorities.
6. The alleged victim's parents/legal guardians will also be notified, unless the facility has official documentation showing the parents or legal guardians should not be notified.
7. If a juvenile court has jurisdiction over the alleged victim, and contact information is able to be obtained, the Administrator On-Duty or designee will also report the allegation to the alleged victim's attorney, juvenile probation officer, or other legal representative of record within 14 days of receiving the allegation. All attempts to contact the child's attorney or receive contact information for the child's attorney will be documented.

115.361 (c): Only designated employees specified by policy should be informed of the incident in order to respect the victim's privacy, security, and identity. All allegations of sexual abuse shall be handled in

a confidential manner throughout the investigation. All conversations and contact with the alleged victim should be sensitive, supportive and non-judgmental.

115.361 (d): Medical and Mental Health staff interviewed confirmed their responsibility to inform residents under 18 years old of their duty to report and limitations of confidentiality during the intake process.

115.361 (e): PREA Compliance Manager, Administrator On-Duty, or designee shall immediately notify law enforcement authorities. The alleged victim's parents/legal guardians will also be notified, unless the facility has official documentation showing the parents or legal guardians should not be notified. If a juvenile court has jurisdiction over the alleged victim, and contact information is able to be obtained, the Administrator On-Duty or designee will also report the allegation to the alleged victim's attorney, juvenile probation officer, or other legal representative of record within 14 days of receiving the allegation. All attempts to contact the child's attorney or receive contact information for the child's attorney will be documented.

115.361 (f): Staff training and policy mandates that all employees, volunteers, interns, and contractors shall immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in the facility, 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 to the PA. Child Line. The administrator will immediately notify the investigator with authority to investigate criminal unless it clearly not a criminal action. In these cases, the administrator will immediately notify the facility investigator. Policy and training also require reporting any third party reports of sexual abuse, sexual harassment, staff neglect and retaliation.

Compliance was determined by review of policies, training, and interviews with direct care staff and first responders that are not direct care staff, the facility administrator, and the agency head designee and the PREA coordinator.

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

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The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

Vulnerability Assessments

AYFS policy OP-20 Facility PREA Response Plan Following Resident Report

115.362 (a): Facility Policy mandate if an employee determines that a resident is subject to substantial risk of imminent sexual abuse, he/she will take immediate action to protect the alleged victim. Employees should assume that all reports of sexual victimization, regardless of the source of the report (e.g., "third party") are credible and respond accordingly. Only designated employees specified by policy should be informed of the incident in order to respect the victim's privacy, security, and identity. All allegations of sexual abuse shall be handled in a confidential manner throughout the investigation. All conversations and contact with the alleged victim should be sensitive, supportive and non-judgmental.

All staff interviewed indicated they would take immediate action to protect the client. All stated they would keep the client with them and report to the shift supervisor the residents real or perceived concerns of being in risk of imminent sexual abuse. The supervisor will notify on call duty staff. The medical, mental health and administrative staff would assess the danger and make appropriate housing plan to protect the client.

Compliance was determined by review of policies and interviews with direct care staff, non-direct care staff, and the facility administrator.

Standard 115.363: Reporting to other confinement facilities

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

115.363 (a)

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

115.363 (b)

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

115.363 (c)

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

115.363 (d)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

AYFS Policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program (PREA)
PAQ

115.363(a-d) In the event that a Resident alleges that Sexual Abuse occurred while confined at another Facility, the Facility will document those allegations on the Log for Reporting an Allegation of Abuse that Occurred at Another Confinement Facility. The Facility Director will contact the Facility Director or designee where the abuse is alleged to have occurred as soon as possible, but no later than 72 hours after receiving the notification. The Facility will maintain documentation that it has provided such notification and all actions taken regarding the incident. Copies of this documentation will be forwarded to the PREA Compliance Manager and Corporate PREA Coordinator. Any Facility that receives notification of alleged abuse is required to ensure that the allegation is investigated in accordance with PREA standards. If another facility reports that a Resident in their care alleges that Sexual Abuse occurred while confined at an AYFS Facility, the Facility will document those allegations on the Log for Receiving Reports of Allegations of Abuse from Another Confinement Facility. The AYFS Facility will open an investigation in accordance with PREA standards. During the past 12 months, there were no allegations received a resident was abused while confined to another facility nor were there allegations of sexual abuse received by Leadership Development Program from other facilities.

Compliance was determined by review of policies, training module, and interviews with intake staff, the facility administrator, and the agency head designee and the PREA coordinator.

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

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

The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

AYFS policy OP-20 Facility PREA Response Plan Following Resident Report

115.364 (a): Upon receipt of a report that a resident was sexually abused, or if an employee sees abuse, the first staff member to respond will:

- a. Separate the alleged victim and abuser.
- b. Call for emergency medical care for the victim, if necessary.
- c. Immediately notify the Administrator On-Duty and remain on the scene until relieved by responding personnel.
- d. Preserve and protect the scene of the alleged abuse until appropriate steps can be taken to collect any evidence. When appropriate, the staff member will remove all residents from the room or area.
- e. Assign the alleged victim and abuser to separate areas and ensure supervision by a same sex employee.
- f. If the alleged abuser is an employee, student intern or program volunteer, a supervisor must stay with the employee until further instruction is provided by an Administrator (e.g., safety plan, administrative leave).
- g. If the alleged abuse occurred within the past 96 hours, the employee(s) should **request** that the alleged victim *not* take any actions that could destroy physical evidence (e.g., washing, brushing teeth, changing clothes, urinating, defecating, drinking, or eating).
- h. **Ensure** that the alleged abuser *not* take any actions that could destroy physical evidence (e.g., washing, brushing teeth, changing clothes, urinating, defecating, drinking, or eating).
- i. Apart from reporting to designated supervisors, employees shall not reveal any information related to the incident to anyone other than to individuals involved with investigating the alleged incident.
- j. Document detailed description of
 - 1) Victim and abuser locations and affect (e.g., emotions, appearance)
 - 2) Wounds and their location
 - 3) Anything the victim or abuser reported to the employee

115.364 (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. Random staff interviews revealed considerable knowledge of actions to be taken upon learning a resident alleges being sexually abused.

Staff interviewed confirmed they knew their obligations when a resident makes an allegation, or they suspect an incident of sexual abuse has occurred.

Compliance was determined by a review of center training plan, first responder flow chart and interviews with all staff including administrative support staff that do not deal directly with resident, however, do go to the area where resident is located.

Standard 115.365: Coordinated response

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

115.365 (a)

- Has the facility developed a written institutional plan to coordinate actions among staff first responders, medical and mental health practitioners, investigators, and facility leadership taken in response to an incident of sexual abuse? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☐ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

AYFS policy OP-20 Facility PREA Response Plan Following Resident Report

LDP Coordinated Response plan Includes the following:

- Facility Protection Duties
- Staff First Responder Duties
- Supervisory Employees' Responsibilities
- Notifications required when Sexual Abuse is Alleged

- Evidence Protocol – Medical Responsibilities
- Mental Health Responsibilities
- Investigator Responsibilities
- Facility Administrators' Responsibilities
- Actions Required After Report of Sexual Harassment

The center has a coordinated response checklist that provides each of the above disciplines their requirement to fulfill their duties in the coordinated response plan. The plan was reviewed and includes all areas of the center, agency, MOUs including PSP and WIN. In discussion with the WIN executive director, he was able to articulate the victim advocate role to report to the hospital and provide victim advocacy and after action provided emotional support to the victim. In interview random staff and specialized staff all knew their roles as a coordinated response plan. The staff yearly refresher provides training on a coordinated response plan.

Exceed Compliance was determined by review of the Coordinated Response Plan for an Allegations of Sexual Abuse and sexual harassment. interviews with random staff, nurse, mental health staff, victim advocate executive director, shift supervisors, PREA compliance managers and PREA coordinator.

Standard 115.366: Preservation of ability to protect residents from contact with abusers

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

115.366 (a)

- Are both the agency and any other governmental entities responsible for collective bargaining on the agency's behalf prohibited from entering into or renewing any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted? ☒ Yes ☐ No

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)

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

Instructions for Overall Compliance Determination Narrative

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

The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

Sexually Abusive Behavior Prevention and Intervention Program (PREA) (updated 11-03-21)

115.366 (a): In every case where the alleged abuser is an Employee, Contractor or Volunteer there will be no contact between the alleged abuser and the alleged victim pending the outcome of an investigation. Separation orders (e.g., safety plans) requiring "no contact" will be documented by facility management via email or memorandum within 24 hours of the reported allegation. The email or memorandum will be printed and maintained as part of the related investigation file.

AYFS will not enter or renew any collective bargaining agreement or other agreement that limits a Facility's ability to remove alleged Employee 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.

Compliance was determined by interviews with agency head, PREA coordinator and Facility Administrator.

Standard 115.367: Agency protection against retaliation

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

115.367 (a)

- Has the agency established a Policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? ☒ Yes ☐ No
- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

115.367 (b)

- Does the agency employ multiple protection measures, such as housing changes or transfers for resident victims or abusers, removal of alleged staff or resident abusers from contact with victims, and emotional support services, for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations,? ☒ Yes ☐ No

115.367 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: The conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: The conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Any resident disciplinary reports? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Resident housing changes? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Resident 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

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The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

Sexually Abusive Behavior Prevention and Intervention Program (PREA) (updated 11-03-21)
AYFS policy OP-20 Facility PREA Response Plan Following Resident Report
Retaliation Logs

115.367 (a): AYFS policy OP-20 Facility PREA Response Plan Following Resident Report establishes for protection or resident against retaliation and staff for reports of sexual abuse or harassment or cooperation with investigations. Allegations of retaliation shall be immediately reported to the site supervisor or designee. In instances where the supervisor is believed to be involved in the retaliation, the employee shall notify the supervisor or designee at the next appropriate supervisory level. For 90 calendar days, or longer based on continuing need, following a report of sexual abuse, the PREA Compliance Manager (Assistant Director) shall monitor the conduct or treatment of any individual, youth or employee, who were involved in a reported incident, and shall act promptly to remedy any such retaliation. Monitoring steps include reviewing group, or facility assignments, reviewing youth progress reports, periodic status checks with the youth, and performance reviews or reassignments of employees involved in the initial report or investigation. During the last 12 months there three allegation of sexual abuse (one predator) that was monitored for retaliation. AYFS has developed a company form for all facilities managed by the cooperation to document retaliation monitoring.

115.367 (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. The policy identifies measures to

protect staff and residents including the following: a. Initiating housing changes or transfers for resident victims or abusers; b. Removing alleged staff or resident abusers from contact with victims; and c. Providing emotional support services. The interview 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 PREA Compliance Manager identified protective measures that are aligned with the standard, including separating the alleged abuser from the alleged victim.

115.367 (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. AYFS Policy 5.5 requires the monitoring of items identified in this provision of the standard. The PREA Compliance Manager explained during the interview how he 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 ninety (90) days if the initial monitoring indicates a continuing need. There have been no incidents of retaliation during the 12 months preceding the audit.

115.367 (d): In the case of residents, such monitoring shall also include periodic status checks. The PREA Compliance Manager indicated status checks would be initiated with staff and residents. The FOP states periodic status will occur. The Retaliation Status Checklist would be used to document the status checks as well as the Retaliation Monitoring Checklist to document the ongoing monitoring and use of the Retaliation Status Checklist.

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

The assistant facility administrator (PREA compliance manager) indicated he would visit the resident whenever an allegation is lodged by residents or third party immediately and discuss his role to monitor for retaliation. The clinical supervisor indicated that therapist would also monitor for retaliation. The facility administrator indicated he would monitor staff that report and cooperated with any investigations. There are four residents that have gone under the retaliation protocol starting on February 2, 2022. The retaliation log was reviewed and provided that the retaliation monitor is monitoring the resident weekly. In interview with the retaliation monitor, he indicated he sees the victim and predator on a daily basis and continuously asks them if they are doing alright.

Compliance was determined by review of the policies, the monitoring check list and interviews with the retaliation monitor, facility administrator and Agency PREA coordinator.

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

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The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

Sexually Abusive Behavior Prevention and Intervention Program (PREA)(updated 11-03-21)
AYFS policy OP-20 Facility PREA Response Plan Following Resident Report
Statement of Fact

115.368 (a) Sexually Abusive Behavior Prevention and Intervention Program addresses this standard regarding placing residents in isolation who have alleged to have suffered sexual abuse. According to policy, a resident would only be placed in isolation as a last resort if less restrictive measures are inadequate and only until alternative placement could be found. Interviews the assistant facility director, and mental health director stated they would develop a plan to protect the resident. If no other alternative is available, the resident could be moved to a facility to protect the resident. During any period of isolation residents shall not be denied large-muscle exercise, educational programming, special education services and other programs to the extent possible. Residents in isolation would receive daily visits from a medical or mental health care clinician. 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. The facility

has no historical record of ever utilizing segregation or isolation of a resident to protect residents from others due to a threat and allegation of sexual abuse or sexual harassment. Compliance was determined by review of Policy interviews with Facility Director and Assistant Director.

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

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

115.371 (a)

- When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, does it do so promptly, thoroughly, and objectively? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA
- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).] ☒ Yes ☐ No ☐ NA

115.371 (b)

- Where sexual abuse is alleged, does the agency use investigators who have received specialized training in sexual abuse investigations involving juvenile victims as required by 115.334? ☒ Yes ☐ No

115.371 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No
- Do investigators interview alleged victims, suspected perpetrators, and witnesses? ☒ Yes ☐ No
- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.371 (d)

- Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation? ☒ Yes ☐ No

115.371 (e)

- When the quality of evidence appears to support criminal prosecution, does the agency conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution? ☒ Yes ☐ No

115.371 (f)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?
☒ Yes ☐ No
- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

115.371 (g)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No
- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

115.371 (h)

- Are criminal investigations documented in a written report that contains a thorough description of the physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible? ☒ Yes ☐ No

115.371 (i)

- Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?
☒ Yes ☐ No

115.371 (j)

- Does the agency retain all written reports referenced in 115.371(g) and (h) for as long as the alleged abuser is incarcerated or employed by the agency, plus five years unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention?
☒ Yes ☐ No

115.371 (k)

- Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the agency does not provide a basis for terminating an investigation?
☒ Yes ☐ No

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

- When an outside agency investigates sexual abuse, does the facility cooperate with outside investigators and endeavor to remain informed about the progress of the investigation? (N/A if an outside agency does not conduct administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

AYFS Website
 AYFS Policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program (PREA)
 AYFS Policy 5.3 Investigating PREA Allegations
 AYFS policy OP-20 Facility PREA Response Plan Following Resident Report
 MOU with Pa. State Police

115.371 (a): AYFS Policy 5.3 Investigating PREA Allegations establishes the agency Policy that all allegations of sexual abuse or sexual harassment will be investigated, including third party reports of sexual abuse or sexual harassment. All allegation of sexual abuse is referred to PSP for investigation unless the incident is not criminal in nature. When the facility conducts an investigation, it is completed by a trained investigator and is conducted promptly, thoroughly and objectively.

115.371 (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. At LDP

all investigations are conducted by staff that have received special training in sexual abuse investigations.

115.371 (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.

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

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

115.371 (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.

115.371 (g): Administrative investigations shall include an effort to determine whether staff actions or failures to act contributed to the abuse; and 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.

115.371 (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.

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

115.371 (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.

115.371 (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.

115.371 (l): Any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements.

115.371 (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. There are three allegations of sexual abuse that are ongoing at the time of the audit. The three allegations were from on resident perpetrator involving three residents.

During the last 12 months there were three allegations of resident-on-resident sexual abuse. The incident was referred to PSP of investigations.

Compliance was determined by review of the investigation, interviews with the facility investigator, PREA coordinator, Agency Head, Agency website and facility administrator.

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

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The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

AYFS Policy 5.3 Investigating PREA Allegations

AYFS Policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program (PREA)

Investigator Training Curriculum

The facility investigators conduct administrative investigations. The investigator may make a finding of Substantiated, Not Substantiated, Unfounded, or Pending Further Investigation. The finding will be made using the standard of proof of the preponderance of the evidence (51 % of the evidence).

Compliance of the standard was determined by reviewing the policy, investigative report and interview with the agency PREA coordinator and investigators.

Standard 115.373: Reporting to residents

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

115.373 (a)

- Following an investigation into a resident's allegation that he or she suffered sexual abuse in an agency facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded? ☒ Yes ☐ No

115.373 (b)

- If the agency did not conduct the investigation into a resident's allegation of sexual abuse in the agency's facility, does the agency request the relevant information from the investigative agency in order to inform the resident? (N/A if the agency/facility is responsible for conducting administrative and criminal investigations.) ☒ Yes ☐ No ☐ NA

115.373 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? ☒ Yes ☐ No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been indicted on a charge related to sexual abuse in the facility? ☒ Yes ☐ No
- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility? ☒ Yes ☐ No

115.373 (d)

- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility?
☒ Yes ☐ No
- Following a resident's allegation that he or she has been sexually abused by another resident, does the agency subsequently inform the alleged victim whenever: The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility?
☒ Yes ☐ No

115.373 (e)

- Does the agency document all such notifications or attempted notifications? ☒ Yes ☐ No

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

AYFS Policy 5.3 Investigating PREA Allegations

AYFS policy OP-20 Facility PREA Response Plan Following Resident Report

115.373 (a): At the conclusion of an investigation, the facility investigator, PREA Compliance Manager, or staff member designated by the facility administrator will inform the victim of the allegation in writing, whether the allegation has been substantiated, unsubstantiated, unfounded.

115.373 (b): AYFS Policy 5.3 Investigating PREA Allegations requires that if the facility did not conduct the investigation, it will request the relevant information from the investigating agency in order to inform the individual.

115.373 (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.

115.373 (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.

115.373 (e): Policy requires all such notifications or attempted notifications shall be documented. The Statewide PREA Coordinator has developed a form that for notification to residents of the outcome of investigations that includes a signature from the resident.

Based on the investigative reports, review of Policy and interviews with PREA compliance manager and PREA coordinator for AYFS it was determined that the agency is in compliance with this standard.

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

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

115.376 (a)

- Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies? ☒ Yes ☐ No

115.376 (b)

- Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse? ☒ Yes ☐ No

115.376 (c)

- Are disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories? ☒ Yes ☐ No

115.376 (d)

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No
- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

AYFS policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program (PREA)

AYFS policy 5.3 Investigating PREA Allegations

AYFS policy OP-20 Facility PREA Response Plan Following Resident Report

Statement of fact

115.376 (a): Staff is subjected to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

115.376 (b): According to local Policy and interview with facility administrator all allegations of sexual abuse shall be immediately investigated. Upon the conclusion of the investigation, if staff is determined that they were involved in sexual abuse of a resident, that staff will be terminated immediately, and the investigation will be forwarded to law enforcement for further review and charges.

115.376 (c): Disciplinary sanctions for violations of agency policies relating to sexual abuse and harassment other than engaging in sexual abuse will be commensurate with the nature and circumstances of the acts committed. However, most likely any degree of sexual abuse and harassment will be met with termination of the staff member.

115.376 (d): All staff members who are terminated and or resign in lieu of termination due to violations of the sexual abuse and sexual harassment policy shall be reported to law enforcement. Staff who resign because they would have been terminated, are reported to the local law enforcement unless the activities were not clearly criminal.

There has been no adverse action taken against staff for violation of sexual abuse, sexual harassment, child neglect or violation of PREA standards during the last 12 months. Compliance was determined by review of the agency policy, interview with PREA coordinator and facility administrator.

Standard 115.377: Corrective action for contractors and volunteers

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

115.377 (a)

- Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)? ☒ Yes ☐ No
- Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies? ☒ Yes ☐ No

115.377 (b)

- In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, does the facility take appropriate remedial measures, and consider whether to prohibit further contact with residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

AYFS Policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program (PREA)
AYFS Policy 5.3 Investigating PREA Allegations
Volunteer and Contractor Training Program
PAQ

115.377 (a) AYFS Policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program (PREA) provide any contractor or volunteer who engages in sexual abuse is prohibited from contact with residents. The Policies also provide for contractors and volunteers who engage in sexual abuse to be reported to law enforcement and to relevant licensing bodies.

115.377 (b) The documentation and interviews with the PREA coordinator, assistant facility administrator revealed the provision of information to volunteers and contractors that sexual misconduct with a resident is strictly prohibited. In the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer, the facility will take appropriate remedial measures, and consider whether to prohibit further contact with residents, however, would most likely prohibit them from further contact with residents.

Compliance was determined by training curriculum, contractor and volunteer applications and interviews with the PREA compliance manager and Facility Administrator.

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)

- If the agency prohibits all sexual activity between residents, does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

AYFS Policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program (PREA)

AYFS Policy 5.3 Investigating PREA Allegations

PREA posters

PAQ

In interviews with staff at LDP it was noted that LDP is a therapeutic program whose mission is to correct inappropriate behavior while keeping all residents safe from sexual abuse or sexual harassment. Therefore, the use of disciplinary action for non-criminal action would be dealt with through individual and group therapy programming. It may result in further time at the facility to correct the underlying causes of the sexual misbehavior.

115.378 (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. AYFS Policy 5.5 require an administrative process for dealing with violations of resident-on-resident sexual abuse. The Facility Administrator's interview confirms the formal disciplinary process however residents may also be referred to law enforcement for charges regarding resident-on-resident sexual abuse. Sexual activity between residents is prohibited and court or administrative processes and sanctions occur after a determination the sexual activity was coerced. Residents will be disciplined for sexual contact with staff only when it has been determined the staff member did not consent to the sexual contact. AYFS Policy 5.5 provide anyone reporting in good faith will not receive any repercussions. The policies and interview with the mental health staff confirms counseling or other interventions will be offered to address and correct the underlying reasons or motivations for abuse when the resident remains in or returns to the facility after a sexual abuse incident. The interview also revealed any type interventions or treatment services provided are not as a condition for the resident to access participation in the behavior management system, education services, or other programs. The interview with the Facility Administrator revealed the process regarding allegations of resident-on-resident abuse which can include the resident being removed from the facility when other interventions are not effective.

115.378 (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 LDP provides that disciplinary sanctions

are 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 extreme event a disciplinary sanction results in the isolation of a resident, LDP shall not deny the resident daily large-muscle exercise or access to any legally required educational programming or special education services. Policy further provides for daily visits by mental health and medical personnel. Residents shall also have access to other programs and work opportunities to the extent possible and receive daily visits from medical and mental health staff.

115.378 (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 LDP provides that the disciplinary process considers 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. This was confirmed by the interview with the Clinical Director.

115.378 (d): 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. LDP considers whether to offer the offending resident therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse participation. The facility may require participation in such interventions as a condition of access to privileges, but not as a condition to access to general programming or education.

115.378 (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.

115.378 (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. AYFS Policy 5.5 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.

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

The Statement of Fact indicated during this audit period this facility has not had any incidents that require intervention for residents having sexual conduct. There is an ongoing allegation of sexual abuse that is being reviewed for possible intervention. Based on the review of the agency Policy and procedures, observations and information obtained through the staff interview and review of documentation, the facility has demonstrated compliance with this standard.

MEDICAL AND MENTAL CARE

Standard 115.381: Medical and mental health screenings; history of sexual abuse

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

115.381 (a)

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (b)

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (c)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and 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.

The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

AYFS Policy - CL – 06 Admission Record and Assessment Requirements
LDP Medical/Mental Health documentation

115.381 (a) If any of the intake screening forms indicates a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, the facility administrator or other intake officer shall document the information on the Follow up Notification Form. According to the Clinical Director all resident that arrive a LDP are seen by the clinical director within 72 hours of arrival and the same question about victimization is discussed during their initial Mental Health intake. However, the screening staff document and forward a follow up notification form.

115.381 (b) If any of the intake screening forms indicates 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. This same information is discussed with the clinical staff within 72 hours of intake. However, the screening staff document and forward a follow up notification form.

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

115.381 (d): Medical and mental health staff is required to notify residents at the initiation of services their duty to report, limitations of confidentiality, and must obtain informed consent from youth who are 18 years old or older before reporting information about the resident's prior sexual victimization that did not occur in an institutional setting. Residents who report prior sexual victimization or disclose prior incidents of perpetrating sexual abuse, either in an institution or in the community, are required to be offered a follow-up with a medical or mental health practitioner within 14 days of admission/screening.

Compliance was determined by review of the agency Policy and interviews with medical and mental health staff.

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

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The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

AYFS policy OP-20 Facility PREA Response Plan Following Resident Report
AYFS Policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program (PREA)

MOU, WIN

115.382 (a): AYFS policy OP-20 Facility PREA Response Plan Following Resident Report mandate youth victims of sexual abuse receive timely and unimpeded access to onsite and offsite emergency medical treatment and crisis intervention services, the nature and scope as determined by the judgement of medical and mental health professionals. Medical and mental health staff interviews confirmed emergency medical care and crisis intervention services will be provided by medical and mental health staff as required. Observations revealed medical and mental health staff members maintain secondary materials that document services to residents and these staff are knowledgeable of what must occur in an incident of sexual abuse. It is documented through policies and understood by the medical and mental health staff treatment services will be provided at no cost to the victim, whether or not the victim cooperates with the investigation.

Residents are provided access to an outside victim advocacy agency for services through a MOU with WIN which includes but is not limited to emotional support and accompaniment through the forensic examination and investigative interviews. The advocate will go to the facility or the hospital to provide services. Review of medical files shows that medical and mental health staff members maintain secondary materials and documentation of resident encounters. There have been no allegations of sexual abuse during this audit period.

AYFS Policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program (PREA)
Access to Emergency Medical and MH requires resident victims of sexual abuse are offered timely information about and timely access to emergency contraception and sexually transmitted disease prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate and unimpeded access to emergency medical treatment and crisis intervention services. The medical staff have a protocol in place to assist in expediting a resident to the emergency room with specific documentation for the direct care staff. The facility utilizes Local Hospital for emergency medical treatment and SANE.

115.382 (b): If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim pursuant to § 115.362 and shall immediately notify the appropriate medical and mental health practitioners. The interviews with clinical staff revealed residents have unimpeded access to emergency services. The coordinated response plan flow chart provides guidance to staff in protecting residents and for contacting the appropriate staff regarding allegations or incidents of sexual abuse, including contacting medical and mental health staff. The on-call medical list has the names of medical staff and their emergency contact number. The full-time Nurse is generally on-call 24/7 as determined by the interview. Interviews with staff from WIN indicated there is an on call SANE staff available 24/7 for

forensic examinations. There is also a Victim Advocate on call 24/7 to support a resident that has been sexually assaulted.

115.382 (c): Resident victims of sexual abuse while incarcerated shall be 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. The PAQ and interviews confirmed processes and services are in place for a victim to receive timely access to sexually transmitted infection prophylaxis, where medically appropriate. Additionally, follow-up services as needed will be provided by the facility's medical and mental health staff, according to the interviews with clinical staff. The facility houses male only.

115.382 (d): AYFS policy OP-20 Facility PREA Response Plan Following Resident Report Access to Emergency Medical and MH mandates that 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. This was also confirmed through staff interviews. The staff at the WIN victim services indicated there were no costs associated with advocacy, emotional services, and mental health services.

Policy revealed emergency services will be provided by medical and mental health staff. The medical and mental health staff interviews revealed they are knowledgeable of actions to take regarding an incident of sexual abuse. It is documented through policy and understood by the medical and mental health staff that treatment services will be provided at no cost to the victim. Based upon the review of policies, interview with the Medical, mental health staff and interviews with staff from WIN victim services the facility is compliant with this standard.

Standard 115.383: Ongoing medical and mental health care for sexual abuse victims and abusers

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

115.383 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

115.383 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☒ Yes ☐ No

115.383 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

115.383 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if “all-male” facility. *Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☐ Yes ☐ No ☒ NA

115.383 (e)

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if “all-male” facility. *Note: in “all-male” facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☐ Yes ☐ No ☒ NA

115.383 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

115.383 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

115.383 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

AYFS policy OP-20 Facility PREA Response Plan Following Resident Report
LDP documentation

115.383 (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. The clinical Director indicated in interview that the facility would provide treatment as indicated as prior victimization can be part of the treatment needed for recovering youth. The facility makes a referral to mental health for anyone that provides information on prior victimization or past predator behavior in order to comply with the standard. However, the clinical director indicated that all residents that go through intake at the facility are seen by mental health within 72 hours.

115.383 (b): AYFS policy OP-20 Facility PREA Response Plan Following Resident Report includes a provision that 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 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. Residents that are housed at LDP have a follow up plan which includes mental health counseling as needed. The plan also includes the family in supporting the resident. The WIN victim services is part of the PA. Coalition of Victim Services and would provide resident with support programs when released from the center.

115.383 (c): Based on interviews with the medical and mental health staff the facility shall provide victims with medical and mental health services consistent with the community level of care.

115.383 (d): N/A

115.383 (e) N/A

115.383 (f) The Policy and interviews ensure that victims of sexual abuse will be provided tests for sexually transmitted infections as medically appropriate. Testing would be done at the Victim Service or local hospital and follow-up services may be done at the facility, as needed.

115.383 (g) All treatment services will be provided at no cost to the victim, according to DJJ policy and staff interviews.

115.383 (h) 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. Services will include but not be limited to individual, group and family counseling. Additionally, an evaluation or reassessment will be administered utilizing the Vulnerability Assessment.

Based on a review of the PREA policies, and interviews with the Victim Support Services, clinical director, medical staff, PREA coordinator and Facility Administrator the facility is in compliance with this standard.

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

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

115.386 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☒ Yes ☐ No

115.386 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

115.386 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

115.386 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change Policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.386 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☐ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

AYFS Policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program (PREA)
AYFS policy OP-20 Facility PREA Response Plan Following Resident Report

115.386 (a): AYFS policy OP-20 Facility PREA Response Plan Following Resident Report require an incident review team meeting within 30 days of the conclusion of each investigation unless the finding is unfounded. The policy mandates review team participation to include the agency-wide PREA Coordinator, the facility's PREA Compliance Manager, facility administrator, medical and mental health staff. There were no allegations of sexual abuse during the last 12 months that have been resolved and require a IRT meeting.

The interview with the PREA Compliance Manager and a review of the form used to document the incident review team's findings indicate the team: consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse considers 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; examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; assess the adequacy of staffing levels in that area during different shifts; assess whether monitoring technology should be deployed or augmented to supplement supervision by staff.

115.386 (b): The Agency policy requires that the reviews occur within 30 days of the conclusion of the investigation. There has been one allegation of sexual abuse, the PREA coordinator confirmed that the incident review occurred within 30 days of the conclusion of the investigation.

115.386 (c): The policy mandates review team participation to include the agency wide PREA Coordinator, the facility's PREA Compliance Manager, facility administrator, medical and mental health staff.

115.386 (d): The committee reviewed the following:

- 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.

115.386 (e): The policy outlines the requirements of the standard for the areas to be assessed by the incident review team. The interview with the Facility Administrator, review documentation confirmed the incident review team meeting are documented, including recommendations and the document provided to the Facility Administrator. The interview with the Incident Review Team Member confirmed the facility would prepare a report of its findings and any recommendations for improvement when conducting a sexual abuse incident review. He confirmed the team would consider all factors required by the standard. The latest incident team had no recommendations.

Compliance was determined by review of the Incident Review Team form, policy and interviews with the incident review team members, facility administrator and PCM.

Standard 115.387: Data collection

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

115.387 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

115.387 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually?
☒ Yes ☐ No

115.387 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

115.387 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews?
☒ Yes ☐ No

115.387 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☐ Yes ☐ No ☒ NA

115.387 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.)
☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

AYFS Website
AYFS 2021 Annual PREA Report - Final

115.387 (a): A review of reports confirm that AYFS collects incident-based, uniform data regarding allegations of sexual abuse at facilities under its direct control, including contractors, using a standardized instrument and specific guidelines. The format used for AYFS facilities capture the information required to complete the most recent version of the Survey of Sexual Violence conducted by the U. S. Department of Justice (DOJ).

AYFS maintains and collects various types of identified data and related documents regarding sexual abuse incidents. The facility collects and maintains data in accordance with directives by AYFS. AYFS aggregates the sexual abuse data which culminates into an annual report. The agency provides DOJ with data as requested.

115.387 (b): The facility collects and maintains data in accordance with directives by AYFS. A standardized instrument and specific guidelines and definitions are used to assist in identifying the data.

115.387 (c): The format used for AYFS facilities capture the information required to complete the most recent version of the Survey of Sexual Violence conducted by the U. S. Department of Justice (DOJ).

115.387 (d): The facility maintains and collects various types of identified data and related documents regarding PREA. The facility collects and maintains data in accordance with Policy directives

115.387 (e): LDP is a private facility that does not contract with other facilities to house residents.

115.387 (f): AYFS policy mandates that upon request, AYFS 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.

Compliance was determined by reviewing data collections for preceding two years, review of AYFS Policies and interview with the PREA coordinator, facility administrator and AYFS agency head,

Standard 115.388: Data review for corrective action

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

115.388 (a)

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No
- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No
- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response

policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.388 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☒ Yes ☐ No

115.388 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.388 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following polices, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

AYFS 2021 Annual PREA Report – Final

AYFS Policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program (PREA)

115.388 (a): AYFS Policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program (PREA) recognizes the purpose of conducting annual reports and annual PREA assessments are to 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 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. Further 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.

115.388 (b): A review of the annual reports for the last 2 years included 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.

115.388 (c): The annual report is reviewed by PREA coordinator, his supervisor and agency administrative staff and signed by the Agency Head. Compliance was determined by the PREA policy and website review.

115.388 (d): AYFS Policy 5.5 indicates that all information that is placed on the website will not include personal identifies. 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.

Compliance was determined by reviewing data collections for preceding two years and review of AYFS website.

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.

The following policies, directives, memorandum and agency or facility supplements were reviewed for compliance with this standard.

AYFS Policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program (PREA)
Annual Report

115.389 (a)(b): AYFS Policy 5.5 Sexually Abusive Behavior Prevention and Intervention Program (PREA)-Data Collection and Review requires that data be collected and securely retained for 10 years. The aggregated sexual abuse data was reviewed, and all personal identifiers are removed. The website included all operated facilities. Compliance was determined by review of the website and interview with the agency PREA coordinator.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

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

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard.*) ☐ Yes ☒ No
- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the

agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☒ Yes ☐ No ☐ NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with residents? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

LDP meets the requirements of this standard based upon the following evidence: Since being incorporated as a nonprofit organization, AYFS has ensured one-third of all operated detention centers and all contracted residential facilities have been audited as evidenced by the Final Audit reports provided on the Agency's website. The Auditor was provided complete access to the facility and observed all areas of the facility's buildings and grounds. Additionally, all relevant documents were provided upon request. The facility made space available for private staff and resident interviews.

Residents were provided information on the “Notice of the Auditor’s Onsite Visit” regarding how to send confidential information to the Auditor. No correspondence was received by the Auditor.

Standard 115.403: Audit contents and findings

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

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

This is the third PREA audit for this facility. The previous audits were conducted in 9/2016 and 3/2019. Each audit was conducted by a certified PREA auditor. Both audits were located on the agency website and were reviewed by the auditor.

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.

Robert Manville

April 30, 2022

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.