PREA AUDIT REPORT ☒ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: March 27, 2017

Auditor Information			
Auditor name: Maureen G. Raquet			
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Email: mraquet1764@comcast.net			
Telephone number: 484-366-7457			
Date of facility visit: August 22,23,2016			
Facility Information			
Facility name: Westmoreland County Regional Youth Services Center			
Facility physical address: 2771 South Grande Blvd. Greensburg, Pa. 15601			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 724-830-4200			
The facility is:	☐ Federal	☐ State	☒ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☐ Correctional	☒ Detention	☐ Other
Name of facility's Chief Executive Officer: Dirk Matson			
Number of staff assigned to the facility in the last 12 months: 27			
Designed facility capacity: 24 Total beds Detention – 16, Shelter-8			
Current population of facility: 17			
Facility security levels/inmate custody levels: Secure			
Age range of the population: 10-20			
Name of PREA Compliance Manager: Dirk Matson		**Title:** Directoor of Human Services/PREA Manager	
Email address: dmatson@co.westmoreland.pa. us		**Telephone number:** 724-830-3663	
Agency Information			
Name of agency: Westmoreland County Regional Youth Services Center			
Governing authority or parent agency: *(if applicable)* Westmoreland County			
Physical address: 2 North Main Street, Greensburg, Pa15601			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 724-830-3145			
Agency Chief Executive Officer			
Name: Dirk Matson		**Title:** Human Services Director	
Email address: dmatson@co.westmoreland.pa.us		**Telephone number:** 724-830-3663	
Agency-Wide PREA Coordinator			
Name: s/a		**Title:** s/a	
Email address: s/a		**Telephone number:** s/a	

AUDIT FINDINGS

NARRATIVE

The PREA (Prison Rape Elimination Act) Audit of the Westmoreland County Regional Youth Services Center was conducted on August 22, 23, 2016 by Maureen G. Raquet, Raquet Justice Consultants LLC, a Department of Justice Certified PREA Auditor for Juvenile Facilities from Saint Peters, Pa. The PREA Audit posting notifying residents, staff and visitors of the Audit was posted in all common areas and living units on June 16, 2016. A picture of this posting was taken and emailed to the Auditor on this date. The facility was required to keep these notices posted during this six week pre-audit period and they did so. A flash drive with a Pre-Audit Questionnaire and important documentation was received by the Auditor in her Post Office Box on July 8, 2016. The information contained on the flash drive included a schematic of the facility layout, the mission statement, organizational chart, pamphlets, brochures and posters, forms, educational curriculum for residents, training curriculum for staff and the PREA Zero tolerance policy on sexual abuse and harassment. Throughout this pre-Audit period there were several conference calls as well as emails with the Director/PREA Coordinator to discuss and clarify information and policy. The changes, additions and deletions were made and submitted to the Auditor prior to and during the onsite portion of the Audit. The on-site portion of the Audit on August 22, 23, 2016 started with an introductory meeting with the Director/ PREA Coordinator. The tour of the facility was conducted by him immediately following this meeting. During the tour, I saw postings for the Audit in both Detention and Shelter, in every classroom, all common areas and in the front lobby. The Audit posting in the Detention Unit had been removed, although a staff told me it had been there as recently as two days before. It was posted again before the end of the onsite and verified visually by the Auditor. Additionally, there were posters for reporting and victim support through the Blackburn Center and sexual abuse awareness throughout the facility, in both Spanish and English. These were large themed posters, which caught the eye and were specifically chosen for the age of the residents.

Residents can use a phone on the living unit to call the Blackburn Center or "Child Line" to confidentially report. Child Line is Pennsylvania's Child Abuse Hotline, run by the Pa. Department of Human Services. The phone was in an open area where there was no privacy, but there is also a private phone in the staff office. One resident in Detention volunteered to show me how you could take staff aside and privately request to use the phone to report. Some of the reporting posters had tear off numbers for the Blackburn Center. Residents can also file a grievance or report to parents during once a week visiting or their daily phone call.

While in the Medical Unit, I saw a private examining room, where the doctor conducts physicals without a child care staff present in the room with a door that closes. Posters were added to the Medical Unit during the Audit.

During this tour, I saw cameras throughout, but they are not used to supplement supervision, as they are not monitored. I spoke to on duty staff and residents in both Shelter and Detention regarding unannounced rounds performed by the Director. They stated that he conducts them on all shifts, including holidays and weekends. I picked a random 2:00 AM round from a log of rounds and saw a video recording of it. The storage capability for the recordings is about one month.

I also spoke to Intermediate Unit teachers, clerical staff, a janitorial staff person and a Doctor during the tour and throughout the onsite and they all stated they received PREA education.

The Blackburn Center is a victim advocate program as well as a member of thePennsylvania Coalition Against Rape. This program accepts reports and provides support services. Westmoreland County has an MOU with them and I spoke to a staff person there, prior to the on-site, who confirmed services in the MOU and stated that they were unaware of any incidents or problems at this facility.

Outside of every doorway leading into a dormitory were "knock and announce" posters. The residents have privacy in their rooms and are able to place a cardboard curtain over the window when changing or using the bathroom. All residents have access to pencils and other writing materials both in their rooms and throughout the units. The residents shower one at a time and a staff person is stationed outside of the bathroom area.

The classrooms are utilized for family visits as well as for education. There were posters outside of these rooms in the hallways. Since this space is also used as a visiting area, I requested bi-lingual posters in the classrooms themselves. This was done and verified before the conclusion of the on-site.

There are PREA postings everywhere in this facility including both staff and resident bathrooms.

On the first day of the on-site, I saw residents being supervised in a group setting in the multipurpose room in Shelter while they were eating breakfast and in the living unit of Detention. On the second day of the onsite I saw group supervision in the Shelter classroom. The supervision ratio exceeded that of both PREA standards and the DPW 3800 regulations in both programs on those days.

At the conclusion of the tour and for that day and the next, I conducted interviews of Specialized staff including: the Director/ PREA Coordinator, the Human Resources Manager, the Director of Human Services, a staff responsible for Intake Education and conducting Risk Assessments, a teachers's aide, who is a contracted employee, and a volunteer. It should be noted that there are no Medical staff in this facility, except for a contracted physician who conducts physicals. An agreement with the County office of Behavioral Health will allow for a Mental Health liaison to conduct 14 day assessments when she returns from Family Leave. She was not available for interview and has not yet started this position.

Subsequent to the tour, I was provided with rosters of the 24 direct care staff from all three shifts from both Detention and Shelter and I randomly chose 10 staff to be interviewed, 5 from Shelter and 5 from Detention.This random sample represents 41% of the direct care staff. One staff was part time and nine were full time. I arrived at 7:00 AM on Tuesday, the second day of the onsite to accommodate interviews of midnight staff. Staff work rotating shifts, permanent shifts and swing shifts.

During the Audit, there were 17 residents in the facility: 9 in Detention and 8 in Shelter. I interviewed 10 random residents: four from Shelter and six from Detention representing 58% of the population. I selected them from a roster provided to me after the facility tour. The

rosters were divided by Shelter and Detention. There is only one housing unit for each program. I requested, prior to the onsite, that all residents be identified on the roster by category: those who disclosed a prior sexual abuse, those who reported a sexual abuse, those that were identified as vulnerable or aggressive, those that identified as LGBTI, and those with any disabilities or who were not English proficient. There were no Transgender or Intersex residents in the population. One of the girls I interviewed self-identified as bi-sexual. Two residents disclosed prior sexual abuse unrelated to this facility. One resident was a perpetrator and there were no disabled or non English proficient residents.

I reviewed the 10 staff files of the random staff I interviewed and this included those of 3 new staff. There were no recent promotions. All had current and appropriate child abuse clearances and criminal history checks, however prior to 2015, they had not been conducted every five years. All staff had PREA education and refreshers recorded in their training files. I reviewed the 10 resident files of those I interviewed and two files of discharged residents for timely administration of the Vulnerability Assessment and timely education. The risk assessment was being done in a timely fashion but was not re-administered every 90 days as stated in policy. There was documentation of timely education in all but one of the resident files. One resident, a Direct File case, had been admitted prior to the implementation of PREA Education at this facility. He was subsequently educated. All education, including the required 10 day education is conducted at Intake or within 24 hours of Intake.

There have been no allegations of sexual abuse or sexual harassment at the facility in the past 12 months. Westmoreland County Regional Juvenile Services Center only conducts post incident administrative reviews of incidents. All other criminal incidents are investigated by the Westmoreland County Park Police and Pa. Child Line. An MOU with the police was signed and was provided to the Auditor prior to the 45 day Interim report. An MOU with Excela Health Latrobe is being negotiated and will be sent to the Auditor. This medical facility will provide Forensic Medical Exams and has SAFE/SANEs in the ER.

Prior to, during and subsequent to the Audit, the Auditor received anonymous communications in the form of a phone call, texts and a letter in her PO box. Both the phone call and texts were from the same person. All communications relayed the same information regarding what they believed was an unreported PREA violation between an employee and a Shelter resident. Upon receiving the first communication, immediately prior to the onsite portion of the Audit, I contacted and interviewed two law enforcement officials from two different entities, one who personally completed the investigation, and additionally the Western Regional Director for the Pa. Department of Human Services. The law enforcement officials stated that the report they received did not allege an incident of sexual abuse or sexual harassment, but a violation of Youth Center policy. The County requested a complete investigation by the County Detectives so that this incident was completely transparent. Both officials interviewed stated this incident was unfounded. I was not permitted to review their reports. Pa. DHS stated there were no allegations against the named employee. During the onsite portion of the Audit, I interviewed the Director of Human Services for Westmoreland County and he shared with me his investigation of the incident which included staff and resident statements. He also stated that the allegation was for violation of Youth Center policy and was unfounded.

During the onsite portion of the Audit, during random staff interviews and without prompting, one staff person discussed her concern regarding the same incident. Two other staff interviewed also discussed it, but stated they believed it was "over exaggerated" and anonymously reported for other reasons. The Pa. Child Protective Services Law requires staff to report any incident or knowledge of sexual abuse under penalty of law. All staff stated they are aware of this, however as noted above there were no reports made to Pa. Child Line by staff.

It is not in the Auditor's jurisdiction to investigate an incident, but rather to determine if policy and procedure were followed that provide for reporting and the safety of the residents. After interviewing all of the above and reviewing reports of the incident, I feel that a thorough investigation was conducted and all policies and procedures were followed

At the conclusion of the two days on-site, an Exit interview was conducted with the Director/PREA Coordinator and the findings below were discussed along with recommendations for corrective action and best practice.

DESCRIPTION OF FACILITY CHARACTERISTICS

Westmoreland County Regional Youth Services Center is a 16 bed Juvenile Detention Center and a 8 bed Shelter. It was built in 1978 and was remodeled in 2010. This facility also houses the Westmoreland County Juvenile Probation Department as well as a Juvenile Courtroom. The Detention Program has just expanded its license from 12 to 16 beds and is coed. The residents range in age from 10-20 and in 2015, there were 156 admissions;129 male and 27 female. The average length of stay for the Detention program is 20.9 days. This Detention program also houses "Direct File" Juveniles who are under the age of 18. These juveniles have been charged as adults under Pa. law, but are housed in the Detention Center until they go through the Adult Court Process, or until they turn 18, at which time, they are transferred to the County Jail. During the time of the onsite portion of the Audit, there were 9 residents in Detention, which included two direct file residents and one female detainee. The female resident was released during the Audit. Fourteen Pennsylvania counties have contracts with Westmoreland to house their Detention residents. The Shelter program has 8 beds and is also coed. The license is for children ages 12-20; admissions younger than that would be on a case by case basis. In 2015, there were 111 admissions, 59 male and 52 female and the average length of stay was 22.28 days. Residents are placed in this Shelter either by Juvenile Probation or the Office of Children and Youth, although many of the children are on a shared caseload and have a probation officer and a caseworker. These admissions are limited to Westmoreland County youth. Shelter residents can be either dependent or delinquent and do not require a secure setting. They may be in need of emergency shelter due to a family issue or through no fault of their own or they may be runaways, ungovernable or truant children who do not meet the criteria for secure detention. On the date of the Audit, there were 8 residents, 4 males and 4 females. One female was released during the onsite portion of the Audit. Residents in both programs attend school daily, which is conducted by teachers from the Westmoreland County Intermediate Unit. The new school year started during the onsite portion of the Audit.

Westmoreland County Regional Youth Services employs 27 staff for this facility, including the Director/PREA Manager, clerical, janitorial, a van driver/ kitchen staff, and direct care staff. The direct care staff work both rotating and permanent shifts. There are full and part time staff. The line staff are unionized and represented by SEIU. The contracted employees include the Doctor and the Intermediate Unit Teachers. There are no Medical or Mental Health employees or contracts except for the doctor. An agreement has been put in place for a Master's Level Mental Health Caseworker from Westmoreland County Behavioral Health to act as a liaison to the Detention Center and Shelter and to complete the necessary assessments. There are several volunteers that interact with the residents.

Both the Shelter and Detention programs are inspected and licensed by the Pa. Department of Human Services under the 3800 Child Care Regulations. Both of these programs are short term temporary placement for a child going through the Court process who cannot remain in his or her home.

This two level, 43,523 square foot concrete block building is located on 86 acres in Hempfield Township, South Greensburg, Westmoreland County, Pa. It is in Western Pennsylvania, about 30 minutes from the city of Pittsburgh. Located on a county campus, it is one of several county owned facilities on this acreage, including the County jail, County Geriatric Center, County Forensic Center and a large apartment building for elderly and low income residents. An employee and visitor parking lot is directly in front of and to the side of the building with the main entrance in the front for the Detention Center, Juvenile Probation and Juvenile Court. The front door and the security there is manned by a Westmoreland Park Police Officer. He walks everyone through a metal detector and sends your belongings through xray. You then enter a beautiful main lobby and sign in at a front desk and receive a visitor badge. There is a spacious and bright waiting area for all who enter, with bench seating and public restrooms. If you are a probation employee or a court participant, you descend to the first level in an elevator, where there is another lobby and reception area for the juvenile court. The small courtroom is in this area. To the right is a holding room for the juveniles awaiting court and it is manned by the Sheriffs department. To the left is the large office area for the Juvenile Probation Department. The upper level of this building houses both Detention and Shelter. To the right of the main entrance on the outside of the building are two large garage doors for a drive-in sally port. Behind the building is a fenced in courtyard for both the Detention and Shelter residents. To the left of the Detention Center is the County jail. The main level of the building relies on electronic locks operated by scanning a keycard; there is a key override. In addition, there is a camera system with about 80 cameras, but they are used to record and are not monitored. This upper level also houses an office for the Park Police assigned to this building and who patrol the entire County campus and for the Sheriffs who escort the Detention residents to and from the Courtroom in an elevator and also transport them outside the building for any appointment or if Court is in the main courthouse.

To the left and behind this large reception area, accessible through locked doors, is the Detention Center and Shelter. The Shelter was originally part of Detention and therefore was built with security in mind. These programs and the populations are kept separate by locked doors at all times. They have separate classrooms and eat in different multipurpose rooms. They share, at different times, the outside courtyard, the gym multi-purpose room and the kitchen area.

Detention has a separate Intake area, with a drive-in sallyport that opens into a large Intake area that has a bathroom, with a toilet and sink and an adjoining separate shower room with a single shower. This bathroom has a door for privacy. There is a large built in reception desk with all forms and paperwork and a bench against the wall. A small table and two chairs are used to conduct the Intake. There is also a "holding room" that has nothing in it and a room with lockers for the residents' personal belongings. This area has cameras, except for the bathroom. There is also a bank of screens for camera monitors and computer infrastructure. In front of this area is the Medical wing. It has several rooms all with doors off of a waiting area. One room has an examining table, light etc. for private examinations and across from it is the doctor's office with file cabinets. There are two other unused rooms in this separate medical wing.

Behind the Detention Intake and toward the back of the building is the Shelter wing. The Intake area is next to a glass door to the outside and has a built in counter with sign in books and forms. Next to this is the Shelter classroom manned by an Intermediate Unit teacher and a teacher's aide. It has traditional desks and decorations. This classroom is also used for visiting. Behind the classroom from a central hallway is the Multipurpose room. This area has window walls and high ceilings and is bright and spacious. There are several long tables with seating for the Shelter residents. They eat their meals here and visiting can also be conducted here. Off to the left of this hallway is the

living unit. When first entering, you step into a lounge type area with a television and eight chairs, next to two tables with 4 permanent stools attached to each. There are books on shelves lining the walls. Across from this area is the staff office, a glass walled area with file cabinets, a desk, a computer, bulletin boards and a medication chart. To the left of the living area are two rooms designated S1 and S2 that are segregated from the 6 other rooms that line the hall on the other side of the living area. There are toilets, sinks and built in beds in each of these identical rooms. There is a long window with outside bars in each room to allow for daylight. The doors to these Shelter rooms do not lock. On the end of the hallway closest to the living area is the bathroom/shower area. This is accessed from a small hallway with an open doorway and a toilet and sink in the front with an open shower and a bathtub in the rear.

Through a hallway and a locked door is the Detention Unit. As mentioned above, there are two common areas, the gym/multipurpose room and the kitchen (that the residents do not have access to) between these two units. As you enter the Detention Unit, there are two rooms that are separate from the rest, but identical to the others with a window to the outside, built in bed, toilet and sink. In the center of the unit is the living area with a computer with headphones, a television, 12 individual chairs for the residents and on the other wall a staff office with a window wall. The bathroom/shower room is next to this with a toilet, sink, and open shower area. Continuing straight through the unit are a total of eight rooms on either side of this area. At the end of the unit is a door leading to the outside courtyard. Directly across from and perpendicular to the staff office is a small hallway with rooms on either side for a total of six. There are 16 single rooms in this area. A locked door in a short hallway next to the staff office leads to the multipurpose room. There are cameras throughout this area, except in the resident rooms and bathrooms.

Through the doorway leading into the unit is a small hallway with a locked doorway leading to an administrative area that houses staff lockers, staff bathrooms, a staff kitchen and break room, the administrator's office, clerical, storage, and empty offices. Adjacent to this area is a suite of rooms marked behavioral health, that is currently not in use and also a secure attorney's office with video conferencing capability and a secure visiting area with a glass partition and counters and seating on either side. It is not currently in use.

SUMMARY OF AUDIT FINDINGS

In summary, after reviewing all policy, curriculum, forms, pertinent information and conducting both staff and resident interviews, the Auditor found that the Facility Leadership and the staff are dedicated to providing a safe and secure environment for its residents. The Director/PREA Coordinator has spent a significant amount of time researching and developing a specific training curriculum for the employees. He has conducted this training himself and the post test he uses to further reinforce important policy and procedure and to demonstrate understanding is a valuable resource. The residents interviewed stated they had been educated and could candidly discuss this education and how they would report. These residents all stated they felt safe in this facility. Overall, the Audit found that sexual safety is a priority in this facility. The Director was open to suggestions regarding best practice, many of which were implemented immediately and during the post Audit time period. A short period of corrective action for three standards described below was agreed upon during the exit interview, and when completed this facility will be in complete compliance with the PREA Standards. It should be noted that the facility leadership changed during the corrective action period. The current director and PREA Coordinator is Dirk Matson, the Human Services Director.

The following standards require further documentation to ensure compliance with the PREA Standards:

Standard #321 Evidence Protocol and Forensic Medical Examination. MOU with Excela Health Latrobe is in the process of being signed and must be submitted when completed. On 12-20-16, I received a signed MOU between Westmoreland County Juvenile Detention Center and Excela Health. This standard has now been met.

Standard #342 Placement of Residents in Housing, Program and Work assignments. Although only one current resident was identified as needing a risk based housing decision, there was no documentation of such. Documentation of 60 days of admissions and the resulting Risk Assessment and documentation of risk based housing decisions needs to be submitted to the Auditor. On 3-14-17, I received documentation of risk based housing decisions for all admissions to Shelter and Detention since 10-1-16. This information has been reviewed and meets the standard.

Standard #381 Medical and Mental Health Screenings. A review of 12 resident files, including those of two discharges, showed one resident, who had disclosed prior victimization, was involved in ongoing therapy. This therapy continued while she was in Shelter. Another resident, who disclosed a prior sexual victimization, refused any medical or mental health follow up and the refusal was documented. Another resident, who was a perpetrator, did not receive timely Medical or Mental Health follow up. Although this review did not disclose a majority of follow up issues, there is currently no system in place to do a timely assessment of those who need to be offered a follow up. As mentioned above, a working agreement is now in place to have a Mental Health Liaison from the County Behavioral Health Department conduct these assessments. However, the staff person who will be conducting these assessments has not been trained or begun working in this capacity due to a Leave. This timeline is open ended and is based upon either the staff person returning and beginning to conduct the necessary assessments or another person filling in during this leave. Once this happens, 60 days of admissions and the necessary follow up needs to be submitted. The Auditor will also need to conduct a phone interview with this Mental Health Clinician to ensure proper education. On 3-14-17, I received documentation of timely Mental Health follow up for all admissions that were identified as disclosing prior sexual abuse or who were perpetrators. I also received and reviewed secondary documentation of a Mental Health Assessment that was conducted in a timely fashion by the trained contracted Mental Health Caseworker/Juvenile Detention Liaison. On 3-24-17, I received documentation of training for the contracted Mental Health Clinician. On 3-27-17, I conducted a phone interview with this Liaison. The interview confirmed that all residents who are required to have a Mental Health assessment in a timely manner are receiving it or their declination is documented. This standard has been met.

Two Standards were exceeded:
#351 Resident Reporting has been exceeded because every possible avenue has been given to the residents for reporting and during interviews both staff and residents could enumerate them. There is a phone in the living unit and staff offices to call Child Line or the Blackburn Center. Posters with these services and "tear away" phone numbers are everywhere in the facility. During the tour, a Detention resident demonstrated how he would report using the phone. There is a grievance procedure and tools, pencils, to use it. The grievance policy and procedure was provided to and reviewed by the Auditor. The grievance procedure is also provided to both residents and parents during Intake as part of the Pa. 3800 Child Care regulations. I saw the acknowledgement of receipt of the grievance procedure in the 12 resident files that were reviewed. Outside support in the way of phone calls to parents, guardians, POs and attorneys, as well as visits are available. The policy, interviews with the Director and interviews with the residents confirm this access. Bi-lingual reporting posters are located throughout the facility. A website for third party reporting was up, running and verified by the Auditor prior to the onsite potion of the Audit. It contains contact information as to whom to report including the Director of the facility and the Westmoreland County Park Police. In the public court lobby there are posters and brochures for reporting.

The second Standard that was exceeded is #331, Employee Training. All employees were trained and most carried their First Responder duties on cards in their wallets. During the interviews they produced the cards to refer to as they would in an emergency. They state that they receive Orientation training that includes PREA, as well as many refreshers. The curriculum provided and reviewed prior to the onsite was comprehensive and included a video, power point, on line training and even included an Autism curriculum. All staff receive mandated reporter training as part of orientation. There was general PREA training and also specialized training for this facilty. Documentation of this training was provided to me onsite in the form of training logs and also acknowledgement of receipt and

understanding of the training in each employee file. Specialized postings were available with first responder duties, that allow for immediate removal from the wall, so that they can be a resource. All 10 random staff interviewed demonstrated understanding and knowledge of their training.

The following standards do not apply:

Standard #312: Westmoreland County Regional Youth Services does not contract with any other entity to provide confinement for its residents.

Standard # 318: Westmoreland County Regional Youth Services has not upgraded its facility or its technology since 2012.

Standard #334: Specialized Training; Investigations: Westmoreland County Regional Youth Services does not conduct any criminal or administrative investigations. Investigations are conducted by the Westmoreland County Park Police and by Pa. Child Line. There are no staff in the facility who have been trained as Investigators.

Standard #368: Post Allegation Protective Custody: The Pa. Child Care 3800 Regulations prohibits the use of isolation. A review of the most recent Pa. Bureau of Human Services Licensing and Inspection Summary does not show any citations for the use of isolation by this facility. The Director stated in his interview that there is no use of isolation in this facility.

All other policies and procedures comply with the Standards

After an extended corrective action period, all documentation was submitted and verifired and additional interviews were conducted by phone. All standards have now been met or exceeded and a final report was submitted on March 27,2017.

Number of standards exceeded: 2

Number of standards met: 35

Number of standards not met: 0

Number of standards not applicable: 4

Standard 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The Zero Tolerance Policy was submitted and reviewed during the Pre-Audit time period. During this time, through emails and phone calls, revisions and additions were made to the policy. The completed Pre- Audit Questionnaire was also reviewed. It meets all requirements of the standards including the required definitions and outlines how the facility will prevent, detect and respond to sexual abuse and sexual harassment. The Mission Statement reflects the focus on the safety and security of the residents.

There is a PREA Coordinator for the facility and he was interviewed and states that he has enough time for his PREA related duties. He is also the Director and the Trainor. His background includes working in a Sex Offender program and as a Children and Youth Caseworker with the responsibility of investigating sexual abuse. This position appears on the facility organizational flow chart that was provided to me pre-onsite and he reports directly to the Westmoreland County Human Services Director, who was also interviewed.

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This facility does not contract with other entities for the confinement of residents, so this standard does not apply.

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

The PREA Policy requires that the facility shall develop, implement and document a staffing plan. I interviewed the Director/PREA Coordinator who developed the policy and who ensures adequate staffing on a daily basis. He conducted a Annual staffing review prior to the onsite portion of the Audit and submitted it for review. This facility regularly exceeds both the ratio mandated by this Standard as well as the Pa. DPW 3800 regulations. In Detention the ratio is 1:6 and 1:12. In Shelter the ratio is 1:8 and 1:16. The staffing plan takes into account all variables mentioned in the standard. A review of the most recent Licensing and Inspection Summary issued by the Pa. Bureau of Human Services Licensing reveals no citations for not meeting these ratios. During the tour, I observed supervision of the residents in the classrooms, living units and multipurpose room.

I received staff schedules for both programs, which are reviewed and changed daily if needed for one on one supervision due to the composition of the resident population or other programming that may be occurring. They are also posted in the staff break area, where I saw them on the bulletin board. There are no deviations from ratio. Mandatory overtime is used to ensure this.

There are over 80 cameras in the building and they are used to both randomly review staffing and to review incidents. They are not live monitored.

Random unannounced rounds of all shifts are conducted by the Director. Logs were submitted to me both prior to the Audit and on-site. During the on-site portion of the Audit, I randomly picked a round and requested and saw a recording of it on a midnight shift. During the tour, residents as well as staff were able to state that the Director conducts these rounds, on different shifts, including holidays. The rounds, although occurring, are not happening on a consistent basis on midnight shifts. Prior to the onsite portion of the Audit, the Director was advised of the inconsistency of midnight rounds and that to be in compliance, at least 60 days of logs would have to be submitted. On October 4, 2016, another round of logs was submitted to meet this standard. In total, 78 days of random unannounced rounds on all shifts over a period of four months were submitted. It should be noted that the Director/PREA Coordinator is the only Administrator and he is conducting these rounds. This standard has been met.

Standard 115.315 Limits to cross-gender viewing and searches

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

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

The policy is in place and education of the staff has been conducted in order to protect the privacy of the residents. I received the curriculum that included training on how to conduct searches of Transgender and Intersex residents in a dignified and respectful manner. Posters in each living unit require "knock and announce", because there are both male and female residents as well as male and female staff. During the tour, I also saw the posters and heard this practiced and both residents and staff could demonstrate for me how this is done. Random staff (10) and residents (10) interviewed confirmed that there is no cross gender viewing or searches. The policy prohibits any pat down searches. A search of a resident is conducted at Intake by a same sex staff using a metal detector and a wand and a clothing search. There were no Transgender or Intersex residents in the population at the time of the Audit, nor had there been. All staff knew that policy prohibits the search of a Transgender or Intersex resident to determine that resident's genital status. All residents shower one at a time in the common bathroom. A staff person is posted outside of the bathroom. There are toilets in the room, but each room had a makeshift cardboard shade on the outside of the door window that can be used to ensure privacy, when toileting. Residents and staff both stated during interviews that residents are able to shower, dress and use the toilet facilities without being viewed by staff of the opposite gender.

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

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

□ Does Not Meet Standard (requires corrective action)

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

The Zero Tolerance Policy provides for those that are disabled or have limited English proficiency, however there were no disabled or English non-proficient residents in the population. PREA posters were in all areas in both English and Spanish. The Spanish posters were added to the classrooms because they are sometimes used for visiting. The resident educational materials were provided to me and contained brochures in Spanish and English, posters in both languages and the educational video on zero tolerance in both. All 10 residents interviewed stated that they were asked during the Intake process if they had any disabilities.

An interview with the Director/PREA Coordinator confirms that necessary accomodations would be made for those residents admitted with minor disabilities. This would be done educationally by the Special Education teachers. I reviewed the staff training curriculum which includes a module on children with Autism. All 10 staff interviewed were able to tell me that they can access the services of a translator and would never use a resident to act as a translator to report sexual abuse. A contract with a Sign language translator was provided prior to the onsite. Also, a contract with a foreign language translator was signed and provided to me prior to the Interim report.

Standard 115.317 Hiring and promotion decisions

□ Exceeds Standard (substantially exceeds requirement of standard)

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

□ Does Not Meet Standard (requires corrective action)

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

I interviewed the Human Resources Manager and she was able to confirm the HR policy that includes Child Abuse Clearances and Criminal History checks. They are conducted prior to employment and include a Pa. Child Abuse Clearance, a Criminal History Check and a FBI clearance. She stated that they are also conducted every five years, but that this is the responsibility of the facility. She contacts previous employers and states that an employee has a continuing affirmative duty to report.

I reviewed the files of 10 staff, including 3 who were hired within the last 12 months, and their files contained the necessary clearances obtained prior to their working with children. There have been no promotions. Although the policy requires these checks to be conducted every five years, this was not done prior to 2015. In 2015, the clearance and checks were conducted on every employee and policy now states that they will be conducted every five years. The same is required of contractors and volunteers by the the County policy and the Pa. CPSL. I saw clearances in the file of a contracted employee. A review of the most recent Pa. BHSL Licensing and Inspection Summary revealed no citations for failing to meet this requirement. The Policy contains all required sections and the interview confirmed practice.

Standard 115.318 Upgrades to facilities and technologies

□ Exceeds Standard (substantially exceeds requirement of standard)

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

□ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These

recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

Interviews with the Director/PREA Coordinator confirm that there has been no major modification to this facility since 2012. There has been no installation or upgrade to the video monitoring system since that time. Policy contained all necessary requirements. This standard does not apply.

Standard 115.321 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Westmoreland County does not conduct Forensic Medical Examinations. Forensic Exams would be conducted at Excela Health Latrobe by SAFE/SANEs. This center is only about 15 minutes away. All evidence gathering and police interviews would be conducted by the Westmoreland Park Police. This Department is responsible for conducting these investigations as well as Pa.Child Line. The facility is still in the process of obtaining MOUs with the medical center. The MOU with the Park Police outlines the repsonsiblities of both the Police and the facility and was provided to me prior to the 45 day Interim report.
An MOU with the local victim advocacy center, the Blackburn Center, was provided to me. Prior to the onsite portion of the Audit, I contacted the center and spoke to an administrator. They confirmed the services outlined in the MOU, including emotional crisis support, providing information and referrals including a victim advocate accompanying a resident for the forensic exam and to police interviews. There were no residents who had reported a sexual abuse. Policy contains all necessary requirements to meet this standard including that the exams will be free of cost to the residents.
Corrective Action: When the signed MOU from Excela Health Latrobe is provided to the Auditor, this standard will be met.
On 12-20-16, I received a signed MOU between Excela Health and the Youth Center. This standard has been met.

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

All policies and procedures in the Zero Tolerance Policy are in place to ensure referrals of allegations to Child Line and to the Westmoreland County Park Police. All 10 random staff interviewed were able to discuss these policies and their role in reporting. The Director/PREA Coordinator was also interviewed and confirmed that all allegations are reported. Pa. Child Protective Services Law requires mandated reporting under penalty of law. The staff receive mandated reporter training as part of their orientation and this is required by regulation. I saw evidence of this training in the Staff training logs that were provided to and reviewed on site.

The public is made aware of who is responsible for investigations and who they can report to in several ways. There are brochures in the Juvenile Justice Services Center waiting area that serves both the Detention Center/Shelter, the Juvenile Probation Department and the Juvenile Court. There are postings throughout this public space and the facility website also includes this information.
There have been no allegations or referrals in the past 12 months.
A signed MOU with the Westmoreland County Park Police was provided and reviewed by me prior to the 45 day report.

Standard 115.331 Employee training

- ☒ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

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

I reviewed the policy, saw the curriculum and the employee training logs. The curriculum includes a training obtained from the NPRC and the Moss group. It also includes how to properly conduct a search of a Transgender or Intersex resident in a dignified and respectful manner and dealing with those residents who may be disabled or have limited English proficiency. The staff training video was generic and the monthly trainings were specific to the facility. The logs contained agendas for staff meetings with PREA topics, monthly trainings with PREA topics as well as orientation and refresher trainings. Refresher trainings are required including one every two years. All 10 random staff that I interviewed were more than adequately trained and were able to answer questions regarding their training and understanding of it. Most staff stated they had received PREA related training several times in the past year and as recently as last week. Many of the staff carried first responder cards in their pockets which they were able to refer to during interviews. The 10 employee files that I reviewed had a sign off that they received training and that they understood it. As part of the demonstration that they have understood their training, a staff person must pass a PREA test. This test was provided to me and is an excellent training tool. There are postings throughout the facility, including the staff breakroom and the staff bathroom that include PREA information.
The staff training exceeds this standard.

Standard 115.332 Volunteer and contractor training

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

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

I interviewed a teacher's aide from the Shleter program, who is employed by the Westmoreland County Intermediate Unit and is a contracted employee. She received the full employee training, because she interacts with the residents on a daily basis. She was able to tell me when she received the training and what it consisted of. She could tell me that she was a mandated reporter and who she would report to in the facility as well as to her supervisor. I saw the documentation of this training in her file.
All contractors receive training and the type and level is based on the kind of and the level of interaction with the residents. During the onsite, we discussed having both the Park Police and the Sheriffs assigned to the Juvenile Services Center receive PREA training and signing an acknowledgement of this. This was done and provided to me before the conclusion of the onsite.

I was provided with the brochure that is used to educate contractors.
I also interviewed a volunteer, who along with her husband, visits the children once a month and has for over 30 years. She stated they both received a three hour training on the zero tolerance policy on sexual abuse and sexual harassment. She was able to tell me who she would report to in the facility. I saw documentation of this training in her file.
The PREA Policy contains the requirement for this training.

Standard 115.333 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I saw the pamphlet given at Intake, and posters and pamphlets throughout the facility. The residents also view a video obtained for the PREA website and produced by the Texas Juvenile Justice Department. I interviewed 10 random residents from both the Shelter and Detention programs who were able to tell me that they had been given the education at Intake and all had a good understanding of the education. All staff persons are responsible for educating the children at Intake. I interviewed a supervisor who also conducts intakes and he described how he educates the residents with the video and with brochures. All education including the 10 day follow up is done at Intake. If a resident arrives in the middle of the night, or is unable to participate in education during the Intake process, the video is viewed during the next awake shift. I reviewed 12 resident files (10 active and two discharges) and there were sign offs for timely Intake Education if they had been admitted after January 2016, the go live date for Resident PREA Education. Ongoing education is on display thoughout the facility. There are large PREA posters in both Spanish and English in all common areas. One resident who had been there for 16 months told me he has seen the PREA video once a month since the inception of PREA at the Detention Center.
The PREA policy outlines when residents are to be educated and what the education needs to contain.

Standard 115.334 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There are no Investigators at this facility. Any Administrative investigation that is conducted is to gather enough information to report the incident to the Westmoreland Park Police and to Child Line. The Pa. CPSL does not allow an investigation by the facility prior to Pa. DHS conducting an investigation. This standard does not apply.

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There are no Medical or Mental Health Staff currently employed at the facility. A contracted doctor conducts physicals as required by the Pa. 3800 Child Care regulations. All other medical needs are provided in the community. Excela Health Latrobe provides Forensic Medical Exams conducted by SANE/SAFEs. Medications are administered by staff. During the tour I spoke to the doctor, who is at the facility no more than twice a week for a short period of time, or not at all if there are no admissions. He stated he had received training on the Agency's zero tolerance policy on Sexual Abuse and Sexual Harrassment. I received his signed acknowledgement of training. Policy requires training of Medical Staff commensurate with their level of contact with the residents. A contracted Mental Helath Caseworker conducts assessments of those children identified in the Risk Assessment that require one. She was interviewed by phone on 3-27-17 and stated she received the PREA training that all staff receive, Mandated Reporter training and an NIC online training. I also received documentation of this training. This standard has been met.

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The PREA policy outlines the information that is needed to ascertain whether a resident is vulnerable to sexual abuse or sexual harassment or whether they are a danger to the other residents because they are sexually aggressive. The tool used to screen is one that is commonly used and takes into account many variables when determining vulnerability or aggressiveness including the following: age, physical appearance, prior sexual abuse, prior sexual offenses, LGBTI identification, learning or other disabilities, previous institutionalization, bullying, and other factors. Prior and subsequent to the onsite portion of the Audit, this tool was tweaked to best meet the needs of the residents and to capture all information from all sources. The final formatting was submitted to the Auditor prior to the 45 day report. The screening is conducted at Intake by all staff. I interviewed a supervisor who does most of the Vulnerability Assessments and he states he takes into account other information from Probation Officers, Caseworkers, Health and Safety Assessments and parent phone interviews. He has access to the computerized data system utilized by the Juvenile Probation Department to check for prior contacts. He uses a combination of an interview and then asking questions from the instrument. A score is awarded based on the above to determine if a child is identified as vulnerable or aggressive. I reviewed 12 resident files for timely administration within 72 hours of Intake and 11 out of the 12 were completed in a timely fashion. The one that was not was a child who had been admitted prior to February 2015, the date when one was completed for all admissions. One of the files had a second Assessment, but not within the 90 day timeline as outlined in the policy. The screens are confidential and are limited to child care staff. Teachers and janitorial staff would not have access to these screens. During the time of the onsite, we discussed assigning only supervisors to administer the risk assessment for consistency and then documenting important information in a staff log, rather than including the Vulnerability Assessment in the log. These changes were implemented subsequent to the onsite but prior to the interim report. The Director and/or the Mental Health Liaison are conducting the Vulnerability Assessments and the pertinent information that is ascertained is recorded on a "Risk Responsivity" sheet for the other staff in order to be more confidential. This change was made subsequent to the onsite, but priot to the 45 day report and is a better practice.
The policy requires that any resident who is there for more than 90 days has a reassessment according to facility policy. Most residents are

there for a very short period of time, because this is a detention center. However, the residents who are "Direct Files" and are awaiting adult trials are there for an extended period of time. There are currently two such residents in the population that can be reassessed within the timeline in the policy. When this is completed, those assessments need to be sent to the Auditor for verification and compliance with the standard. Both reassessments were administered and sent via email to the Auditor prior to the 45 day Interim report. Although the policy states 90 days, one reassessment was for 180 days and one for 360 days. The average stay in Detention is approximately 20 days and there are no other long term residents at this time, so I am accepting this documentation to meet the standard.

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I interviewed the Director/PREA Coordinator and a Supervisor, who is responsible for administering the screen. Although both vulnerability and aggressiveness are considered when housing residents, as identified on the Risk Assessment, the risk based housing decision is not documented anywhere. During the tour, I saw the two rooms separate from the others on both the Shelter and Detention units where an identified resident could be housed.

One boy in the population was scored as aggressive, but there was no documentation of why or why not risk based housing was considered. I interviewed one girl who identified as bisexual and she stated she was not subject to specialized housing due to her sexual preference nor was she discriminated against in any way. There were no Transgender or Intersex residents in the population during the onsite portion of the Audit, but the PREA Policy requires that a Transgender or Intersex resident be allowed to give input regarding their housing and that their safety and security is foremost is making a housing decision. According to the policy, they would be reassessed at least every 30 days to determine whether there are any threats to their safety. The use of isolation is prohibited in policy and by the Pa. 3800 Child Care regulations. During the tour, I did not see any area that was currently being used to isolate residents. The "holding room" at Intake was a holdover from when isolation was allowed, but is no longer used for that purpose according the the Director.

During the onsite I was shown a "Risk Responsivity Form" that is filled out after the Vulnerbility Assessment is conducted. It will allow for the documentation of important information and will document risk based housing decisions and Medical and Mental Health follow up for an identified child.

Corrective Action: Sixty days of all new admissions with documentation must be submitted to show that risk based housing is considered based upon the VAI score in order to meet the standard.

On 3-14-17, I received documentation of risk based housing decisions for all Shelter and Detention Admissions since 10-1-16. The Risk Responsivity forms document identification of vulnerable or sexually aggressive residents, as well as LGBTI residents and whether risk based housing was considered. It further documents the reasons why a child was or was not placed in a room that allows for specialized supervision. A review of this documentation, including a "risk responsivity" form for all admissions during the stated time period, shows compliance with this standard.

This standard has been met.

Standard 115.351 Resident reporting

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This standard has been exceeded. I interviewed 10 random staff and 10 random residents who all could tell me of the many ways to report: in writing, verbally, anonymously and through third parties. There are brochures in both Spanish and English provided to residents during Intake. During the tour, I saw postings for the Blackburn Center with both addresses and "tear offs" with the phone number to report. A resident in Detention volunteered to show me how a resident could privately report by using the phone. The Grievance procedure is another avenue for reporting and is required by the Pa. Dept. of Human Services. It is monitored during their annual inspection. Both parents and residents must be advised during Intake and must sign off on this procedure. These acknowledgements are in the resident files and there were no citations for not doing this. During the tour, I saw that children had pencils and paper they could use in their rooms for filling out a grievance or writing a letter. Phone numbers and addresses for reporting were everywhere. The method that most staff and residents who were interviewed related was using the phone to call the Blackburn center or tell a parent or probation officer during visits. The residents can make a phone call every day to a parent or a grandparent. They can call an attorney or a PO. They can have family visits once a week. I was provided with both phone call and visiting policies.
The staff stated they could always privately report to Human Resources or the Director of Human Services. PREA Policy contains all requirements. Because every avenue has been provided for reporting and all staff and residents knew of them, this standard has been exceeded.

Standard 115.352 Exhaustion of administrative remedies

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

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

This facility is not exempt from this Standard. The Pa. Department of Human Services 3800 Child Care Regulations requires that all residents and parents/guardians be advised of the grievance policy upon intake. Both parents and residents sign acknowledgement of receipt of this grievance policy and this is monitored by the inspecting agency. There have been no citations for failure to notify residents and parents on the most recent Inspection and Licensing Summary that I reviewed. Policy contains the necessary information and timelines regarding grievances. Parents and/or third parties are permitted to file a grievance for a resident even if the resident refuses and that is why they are notified of the policy at Intake. A grievance has not been used to report sexual abuse, even though it is one of the avenues that both staff and residents interviewed stated can be used. I reviewed the grievance policy and it meets the standard.I was provided with the grievance form. I also reviewed 12 resident files and they contain acknowledgement by both parent and child of receipt of the grievance policy.
This standard has been met.

Standard 115.353 Resident access to outside confidential support services

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

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

There is an MOU with the Blackburn Center, the local Victim Assistance Agency, that outlines the access to confidential support services. There are posters describing these services with toll free numbers to the hotline and how to access them. A pamphlet given to each child at Intake gives this information. I interviewed 10 residents and more than a few were able to describe these services to me and also knew of the mandated reporter responsibilities of the staff, but that otherwise the communication would be confidential.

I called and spoke to a staff person at the Blackburn Center prior to the on-site portion of the Audit, and she confirmed the services contained in the MOU.

Residents are also given confidential access to their attorneys, probation officers and caseworkers as well as phone calls and visting with parents and guardians.

The PREA Zero Tolerance Policy contains all requirements.

This standard has been met.

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Third Party Reporting information is posted in both Spanish and English in the public lobby and visiting areas. It is also listed on the grievance form that the parents receive. It is posted on the Westmoreland County Juvenile Justice Services website, verified by the Auditor. The website provides information for reporting to the facility, Child Line and the Westmoreland County Park Police. There have been no third party reports in the last twelve months. Policy was reviewed and meets standard.

Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I interviewed the Director/PREA Coordinator, 10 random staff, and a teacher's aide. All knew the policy and the law regarding reporting and confidentiality. They knew how to report and who to report to. All staff receive mandatory reporter training as required as part of their orientation training by the Pa. 3800 Child Care regulations. The Director also notifies parents/guardians, probation officers, caseworkers and attorneys of record within 24 hours of receiving an allegation. This is documented in the resident file as part of the state regulation requiring a "HCSIS" report within 24 hrs. Policy meets standard.

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

I interviewed 10 random staff and the Director. All knew what actions to take to ensure the safety of a resident. All actions would take place immediately and would be documented. There have been no incidents of this type in the past 12 months. Policy meets standard.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There have been no incidents of this nature in the past 12 months. Upon receiving a report, the director would report to Child Line and the other facility within 72 hours and would document this. If the County facility was the subject of the allegation, he would call Child Line within 72 hours and also notify the Westmoreland County Park Police immediately. Policy meets standard.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Staff first responder duties are enumerated in policy. They are also in the curriculum for staff training. Most staff carry a card with their first responder duties on their person. I interviewed 10 random staff and they knew their responsibilities, or referred to their cards. They could discuss keeping the resident safe and protecting the site for evidence collection by the police. Additionally, all staff bathrooms contain a "bathroom gram" on the paper towel dispenser. It is a list of the first responder duties. It can be pulled off to use in case of emergencies.

There have been no incidents in the past 12 months, so there were no staff who have actually performed those duties, however after interviewing the 10 random staff, I feel that they would be able to perform these duties.
This standard has been met.

Standard 115.365 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The Executive Director could describe the coordinated response during his interview. It is contained in the Zero Tolerance Policy and is also a separate document that was provided to me and uploaded. The Policy lists who is to be notified and what steps to take and when to ensure the response. There have been no incidents that have required this in the past 12 months. However, the policy is clear and the coordinated response document is a step by step, so that I feel that if a response was needed the policy and procedure would be followed.
This standard has been met.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This is contained in policy and an interview with the Director confirms that there is nothing in the Union contract that prohibits protecting residents from contact with abusers. A copy of the most recent Union contract with SEIU was provided to me. I reviewed it and did not find any restrictions. The contract allows for management to removes taff from the facility pending the outcome of an investigation. The Director states that the contract is presently under negotiation and the ability to protect residents will not be changed.
This standard has been met.

Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor discussion, including the evidence relied upon in making the compliance or non-compliance

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

Protection from Retaliation is in the Zero Tolerance Policy. I interviewed the Director/ PREA Coordinator who is the staff person responsible for monitoring retaliation. He could tell me that they can move a staff to a different housing unit. A resident can have his room moved to one of the two separated rooms. The PREA Manager would initiate contact with a victim to ensure that there was no retaliation and would monitor for at least 90 days and probably for the entire length of stay. If a staff person was being retaliated against, Human Resources would become involved. There have been no incidents of this within the past 12 months. This standard has been met.

Standard 115.368 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This standard does not apply, because there is no use of isolation. It is prohibited by the Pa. DPW 3800 regulations and by policy. I interviewed the Director. He confirms that isolation is never used. During the tour, I observed no location where residents are being isolated. The current Licensing and Inspection Summary did not include any citations for the use of Isolation.

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There have been no allegations or incidents within the past 12 months. I interviewed the PREA Coordinator/Director. He confirms that investigations are conducted by the Westmoreland County Park Police and Child Line. Any information that is gathered is used to report and turn over to law enforcement and to implement a protective action plan for the child. At the conclusion of an investigation, an administrative post incident review is conducted. All agency staff cooperate with both Child Line and Law Enforcement. Most of these sub standards are the jurisdiction of the police department and the District Attorney's office. Policy meets standard.

Standard 115.372 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Policy meets standard. Included in this policy is the the statement that no standard higher than preponderance of the evidence is used in substantiating an allegation. This facility does not determine whether an allegation of sexual abuse is substantiated. That is the jurisdiction of the police and child line. There is an MOU with the Westmoreland Park Police that outlines the role and responsibilities of the law enforcement agency and the facility based upon the PREA standards.

Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This is contained in policy. There have been no incidents in the past 12 months, so there was no documentation to review or residents to interview. An interview with the Executive Director confirms that policy would be followed and residents would be notified of the outcome of the investigation. Child Line sends a report to both the victim and the agency with its finding. If only the police were involved, the facility would notify the resident and parents.
This standard has been met.

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This is contained in policy, with termination being the presumptive discipline for sexual abuse. Anytime there is an allegation of sexual abuse against an employee, they are suspended without pay, pending the outcome of the investigation. This was confirmed during interviews with HR, and the Director. Pa. CPSL does not allow the continued employment of a staff person in a child care agency with an indicated or founded child abuse. Discipline would be commensurate with the act. There have been no incidents within the past 12 months.
This standard has been met.

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There have been no incidents within the past 12 months. Interviews with the Facility Administrator confirms that appropriate actions would be taken that include reporting to Child Line and law enforcement. A contractor would be immediately removed from the facility and would not be allowed contact with the residents. The same would apply for a volunteer. Policy meets standard.

Standard 115.378 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There have been no incidents in the past 12 months. Policy meets standard. There would be no discipline for any allegation made in good faith as per Pa. CPSL. If a resident needed to be disciplined, age, intellectual level and mental health issues would be taken into account. All discipline would be on a case by case basis, consistent with other resident disciplines. A resident would be disciplined for sexual contact with a staff person, only if the staff person did not consent to such an act. The facility does not permit any sexual contact between residents, however, such contact would only be reported to law enforcement if it were not consensual or if there was an age of consent issue. I interviewed the Director to determine compliance with this standard.
This standard has been met.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

Whereas the PREA Policy contains all the necessary requirements for appropriate and timely screenings for those who have perpetrated sexual abuse or for those who have disclosed a prior sexual abuse, there is nothing currently in place for this screening.
An agreement with the County Office of Behavioral Health will provide for a Master's Level Mental Health Caseworker to act as a liaison to the Juvenile Services Center and to provide the necessary assessments within 14 days of the administration of the Vulnerability Assessment as required by this Standard and the Facility's policy.
Corrective Action: This contracted Mental Health staff will need to be trained and will then be interviewed by telephone by the Auditor. Sixty days of admissions and subsequent documentation of timely assessment by this staff or written declination by the resident need to be provided to the Auditor to be in compliance with this standard.
On 3-14-17, I received documentation of all admissions since October 1, 2016. Included in this documentation was any resident identified as having disclosed a prior sexual abuse or who was a perpetrator of sexual abuse. Any resident admitted on or after 1-16-17 and thus identified was offered a Mental Health follow up. It was documented as to who declined and who accepted. For those, who requested a follow up the documentation shows that it was conducted within 14 days of the Vulnerability Assessment being conducted. I also received and reviewed a randomly selected admisssion's secondary documentation that included the actual assessment, to confirm this practice. The Juvenile Detention Liaison is contracted through Westmoreland Behavioral Health. I received documentation of her training on 3-24-17. It included PREA Training that all employees receive, Mandated Reporter Training, and an on-line NIC training for Medical and Mental Health staff.
On 3-27-17, I conducted a phone interview with this Juvenile Detention Liaison . She was able to candidly discuss her training and experience and how and why she conducts assessments at the Center. She states that she conducts assessments within 14 days of notification and would conduct it sooner for a resident who had an immediate need. She states the facility does not offer therapy or counseling.
This standard has been met.

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

All residents have access to emergency care, free of charge. This is provided at Excela Health Latrobe. Residents would be offered timely information regarding contraception and infectious disease protection. A mobile crisis team for a Mental Health Emergency can and does respond to the Detention Center. Both of these are community resources. The PREA Policy contains these procedures and staff who act as first responders are aware of this.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The PREA Zero Tolerance Policy describes the ongoing treatment that would be offered to the residents. All female admissions are offered pregnancy tests and would be offered timely and comprehensive information and timely legal access to all pregnancy related information. STD testing is provided for all residents. These services would be provided in the community and meet the community level of care provision. If there was a known resident on resident abuser in the population, a mental health assessment would be conducted within 60 days of identification and offered ongoing treatment. Documentation of this treatment or declination of such would be kept. An interview with the Director/PREA Coordinator verified the information contained in the policy. Policy meets standard.

Standard 115.386 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Although there have been no allegations or incidents within the last 12 months, there is a system in place for reviewing all incidents. A blank copy of the sexual incident abuse review form was provided and uploaded. The Policy requires that within 30 days of the completion of the investigation a review will take place. I interviewed the Facility Director/ PREA Coordinator and a supervisor who would participate on the incident review team. Once the MH liaison is in place, they would participate on the review team as well. The team would also include law enforcement and the Human Services Director, with input from line staff. They would consider whether the incident was motivated by sexual identity, gang affiliation, race, ethnicity or other group dynamics. They would examine the physical area where the incident took place and also monitor the staffing and whether or not cameras or technology should be deployed to prevent such incidents. A report would be prepared by the PREA Coordinator and submitted to the Detention Board and Human Services Director. If there was a recommendation to prevent further incidents, it would be followed or documented as to why it would not. The interviews, the form and the policy indicate to me that although there have been no incidents requiring this review, they are prepared to conduct one if need be.

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

There have been no incidents and therefore no data to collect, but the system is in effect to do so. It would be collected for every incident from all reports by the PREA Coordinator/Director and a report made, and reviewed before being posted on the website. Personal Identifiers would be removed and the data would be aggregated at least annually. The Policy contains the required information.

Standard 115.388 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

Data would be reviewed and corrective action would be taken on a yearly basis to compare from year to year and on an ongoing basis as needed to aid in the facility's prevention, detection, and response to sexual abuse and sexual Harrassment . This is in policy and was confirmed in interviews with the Director/PREA Coordinator. All personal identifiers for residents and staff would be removed prior to this report being made available to the public by way of the website.

Standard 115.389 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

All information would be securely kept by the Director/PREA Coordinator. Any public report that would be posted on the website would redact personal identifiers and this would be noted. A website tab has been provided for the Annual Report and the Audit. All sexual abuse data will be kept securely for at least 10 years. The PREA Policy contains the necessary information to meet the standard.

AUDITOR CERTIFICATION

I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Maureen G. Raquet — March 27, 2017

Auditor Signature — Date