PREA AUDIT REPORT ☒ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: September 23, 2017

Auditor Information			
Auditor name: Maureen G. Raquet			
Address: PO Box 274, Saint Peters, Pa. 19470-0274			
Email: Mraquet1764@comcast.net			
Telephone number: 484-366-7457			
Date of facility visit: June 20, 21, 2017			
Facility Information			
Facility name: Delaware County Juvenile Detention Center			
Facility physical address: 370 North Middletown Road, Lima, Pa. 19037			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 610-891-8660			
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: Mark Murray			
Number of staff assigned to the facility in the last 12 months: 73			
Designed facility capacity: 66			
Current population of facility: 30			
Facility security levels/inmate custody levels: secure			
Age range of the population: 10-21			
Name of PREA Compliance Manager: James Stickney		**Title:** PREA Compliance Coordinator/Training Supervisor	
Email address: stickneyj@co.delaware.pa.us		**Telephone number:** 610-891-8660	
Agency Information			
Name of agency: Delaware County Juvenile Detention Center			
Governing authority or parent agency: *(if applicable)* County of Delaware			
Physical address: s/a			
Mailing address: *(if different from above)* s/a			
Telephone number: 610-891-8670			
Agency Chief Executive Officer			
Name: Mark Murray		**Title:** Director	
Email address: murraym@co.delaware.pa.us		**Telephone number:** 610-891-8670	
Agency-Wide PREA Coordinator			
Name: James Stickney		**Title:** Training Supervisor/PREA Coordinator	
Email address: stickneyj@co.delaware.pa.us		**Telephone number:** 610-891-8660	

AUDIT FINDINGS

NARRATIVE

The Prison Rape Elimination Act (PREA) Audit of the Delaware County Juvenile Detention Center was conducted on June 20, 21, 2017 by Maureen G. Raquet, Raquet Justice Consultants LLC, a Department of Justice Certified PREA Auditor for Juvenile Facilities. This facility was initially audited during the first PREA cycle in March 2015 and was found to be in full compliance on March 23, 2015. This Audit, conducted on June 20, 21, 2017, is a re-audit of the facility conducted during the first year of the second PREA three year cycle. Notice of the Audit was posted on 3-13-17 and again on 5-8-17. I received an email with pictures of the posting in the living and common areas on these dates. The facility was requested to keep these notices posted during this six week period and they were still posted in all areas during the tour on June 20, 2017. There have been no communications received as a result of this posting in the Auditor's Post Office box. On March 13, 2017, I received a flash drive with the completed Pre-Audit Questionnaire and important documentation. During this pre-audit time period, through emails and phone calls with the PREA Coordinator, the uploaded information and important documentation was discussed, clarified and amended. The agenda for the onsite portion of the Audit was emailed to the PREA Coordinator on June 6, 2017. The onsite portion of the Audit commenced with a brief entrance interview with the PREA Coordinator/Training Supervisor and the Director of the facility. The tour of the facility was conducted by both the Director and PREA Coordinator. It should be noted that this Audit was initially scheduled for April 24, 25, 2017, but was postponed due to the death of the PREA Coordinator/Asst. Director.

The facility was clean and well maintained. During the tour, I saw postings for the upcoming Audit in all areas that the residents have access to and in every living unit and in the lobby. In addition, there were posters in both Spanish and English in all areas, including the visiting area, describing PREA, describing Sexual Abuse and providing reporting information for Women Against Rape.

While on the tour, I saw the "PREA Hotline" that is located in the Chapel/Conference Room and that is a hotline to Women Against Rape. There are posters next to the phone with "Hotline" in large letters. All you need to do is pick up the receiver and it dials directly to WAR. I did so and reached the answering service for WAR. During the pre-Audit time period, I contacted WAR (a member of the Pennsylvania Coalition Against Rape, PCAR) and spoke to the Director. The Director confirmed both the reporting capability and all other services in the MOU provided to me, including crisis intervention and providing a victim advocate for the residents. She also stated that there have been no issues or ongoing problems at Delaware County Juvenile Detention

Subsequent to the Pre-Audit Questionnaire being submitted and the phone call to WAR, a resident alleged a staff on resident Sexual Harassment. It was reported to Child Line and the Resident called WAR from the hotline. The allegation was unfounded and all reports and records were provided to the Auditor. All policy and procedure were followed.

Residents were not in school, because the school year had ended and summer school had not yet started. During the tour, some residents were at breakfast, some were doing chores on their units, and some were watching television on another unit. I spoke to several residents who told me they had received PREA education and they told me how they could report; most mentioned the Hotline or the PREA boxes on all living units. I went into one girl's room with her and asked her if she could dress and toilet in privacy, because there is a toilet in the rooms. She stated that male staff always knock and announce when entering the girls' unit and they never cross the line into the hall where the bedrooms are. Only female staff do room checks and run showers. I spoke to staff persons who stated they received PREA training and they told me that Administration conducts unannounced rounds on a regular basis. I also spoke to three kitchen staff who all stated they had received PREA training.

There were postings next to the door for each unit, where the resident bedrooms are, directing the opposite gender staff to announce themselves. I saw this practiced at the door of every unit during the tour. All staff use the walkie/talkie to communicate to the control room when they are entering units or stairwells.

During the onsite portion of the Audit, I saw a supervised breakfast in the cafeteria. Ratio of 1:6 was always maintained or exceeded whether in a group setting or with smaller groups of residents.

All residents receive physicals in the Medical Suite within 72 hours of admission. The Nurse showed me the private exam room where residents are seen. There were reporting posters in the room. The Nurse could tell me what training she had received and how she would report any sexual abuse or sexual harassment. I saw the locked file cabinets that she stated are only accessed by Medical Staff and Administration. I toured the Mental Health clinic, part of the Medical Suite, and saw private offices and locked file cabinets with secondary documentation and limited access.

The Intake Area had a private shower/toilet room. The Intake search procedure was demonstrated for me. Staff stand outside the room and residents change into Delco jumpsuits. The search is not hands on and is conducted by same sex staff. The resident then goes through the admission process which includes viewing a Delco specific Power Point Presentation about zero tolerance and reporting. They are given a pamphlet and sign off on the PREA Zero Tolerance and Reporting Information. The resident also fills out a gender variant search form. The Intake area does not have cameras in the search area and the residents can toilet in privacy. There are PREA posters throughout the Intake area.

A conference room in the front of the building is used for visiting, which occurs 5 days a week. There were reporting posters in Spanish and English in this room as well as in the waiting area in the front lobby. There is an actual Mailbox in the front lobby for parent and visitor reporting as well as signs about sexual abuse and domestic violence.

Directly after the tour of the facility and for the following day, interviews were conducted privately in the chapel/conference room. The following staff and residents were interviewed:

Director who also conducts unannounced rounds

PREA Coordinator/Training Supervisor:

Who conducts unannounced rounds

Monitors Retaliation

Interviews employees and monitors the Child Abuse and Criminal History Clearances

Registered Nurse

Mental Health Therapist

Case Manager who administers the Vulnerability Assessments

Admission's Staff who conducts Intake Education

Caseworker who is a member of the Sexual Abuse Incident Review Team

Psychologist who is a contracted employee

A Yoga Instructor who is a volunteer

10 random residents

10 random staff

Staff are full time and work permanent shifts with permanent days off. Third Shift staff work permanent midnights with rotating days off (6 on, 2 off). A roster of staff working on all units and in Intake were provided to me and I interviewed ten random staff from all shifts, this represents 20% of the direct care staff. There are a total of 73 full time staff and 48 of them are direct care staff. There is a Union, AFSCME DC 88 and a contract has just been approved.

I was given a census of all 30 facility residents, 4 girls and 26 boys, which included all residents that identified as LGBTI, who disclosed a prior sexual abuse, who were disabled or non English speaking. Of the 30 total residents, ten (10) residents were interviewed, two girls and 8 boys. That represents 33% of the total population on the days of the Audit. There were no residents who reported a sexual abuse. There was one resident who reported an unfounded allegation of Sexual Harassment by staff and he was interviewed. There were two residents in the population who identified as Gay and both were interviewed. There were no Transgender or Intersex residents in the current population, but there had been a Transgender girl admission earlier in the year and her file was reviewed. There were no disabled or non-English proficient residents. One resident disclosed prior sexual abuse to staff but she was discharged prior to interviews taking place.

I reviewed the files of 11 staff for required documentation, including one hired within the past 12 months, and the files of 13 residents: 10 active and three discharges. I was provided a census of all admissions from the past 12 months and randomly picked one discharged file from this list. The two other discharged files were those of the girl with the prior victimization who had just been discharged and the Transgender girl from earlier in the year.The 10 active files were those of the residents that I interviewed.

Residents have several means to contact independent agencies to report instances of sexual abuse and sexual harassment as mentioned above: " The PREA Hotline", which goes directly to WAR. Addresses for WAR were posted throughout the facility in both Spanish and English, including the area that is used for visiting. This information is also contained in resident handbooks given to the residents during Intake. They watch an age appropriate Power Point presentation during the Intake process with specific reporting information. There is a PREA box on every living unit. It has PREA brochures with attached reporting forms. They can be filled out and placed in the locked metal box, which is checked by the PREA Coordinator and the Director on a daily bais. Residents have a grievance process for reporting and have ample opportunities to report to parents and guardians through frequent phone calls and visits. Attorneys, Probation Officers and Caseworkers can call or visit at any time.

Staff and residents both knew the reporting avenues and knew that they could report verbally, in writing , anonymously and through third

parties. Most residents were aware of the Victim Advocate and Crisis Intervention Services offered by WAR. Most residents stated they would tell a staff or use the hotline to report.

There are MOUs with Riddle Memorial Hospital for Forensic Examinations with SAFE/SANEs, a MOU with Delaware County Criminal Investigation Division, that conducts Criminal Investigations and WAR. Pa. Child Line also conducts investigations. This information is posted on the facility website.

During the past 12 months, there has been one unfounded allegation of staff on resident sexual harassment and no allegations of sexual abuse. All reports were provided to and reviewed by the Auditor, including the report from Pa. DHS classifying it as unfounded. All reporting polices and procedures were followed. There have been no reports from other facilities of abuse at Delaware County and Delaware County has not received any reports of sexual abuse at other facilities.

At the conclusion of the onsite Audit, a brief Exit interview was held with the following staff on Wednesday, June 21, 2017: the Director of the Facility and the PREA Coordinator. The preliminary results of the Audit were discussed as well as a plan for corrective action.

DESCRIPTION OF FACILITY CHARACTERISTICS

Delaware County Juvenile Detention Center is county run with a 66 bed licensed capacity. It was originally built in 1972 and E wing was added on in the late 1980's. Currently, five, thirteen bed units are in operation, with one being designated for females and the remainder for males. On the date of this Audit, four of the thirteen bed units were being used. The facility had 709 admissions in 2016, 597 male and 112 female. The age range is 10-21. The average length of stay is approximately 16 days, because this is a juvenile detention center, where children are placed by order of the Court or by Juveniel Probation for the protection of the community or to ensure their presence at their hearings. The children attend school and receive testing to aid the Court in disposition. During the on-site portion of the Audit, there were 30 residents, 26 boys and 4 girls. Two of the girls were discharged on the first day of the Audit. The director of this facility is Mark Murray and he reports directly to the President Judge of the Delaware County Court of Common Pleas. AFSCME DC 88 represents Direct Care Staff. There are 73 full time staff, including Detention Officers, Administration, Nurses, and Kitchen staff. Contracted employees include the teachers provided by the Delaware County Intermediate Unit, the Mental Health Care Staff from the Child Guidance Center,the Dentist, Psychologist and the Nurse Practitioner, who conducts physicals. This facility is licensed by the Pa. Department of Human Services under the 3800 regulations governing child care.

The 34,744 square foot building is located on 2.74 acres and is part of a County campus that includes a geriatric center and is adjacent to the 911 Emergency call center. The center is located in Middletown Township, Lima, Delaware County in suburban Philadelphia. It is approximately 1.5 miles from busy U.S. Route 1 and sits off Rt. 352. The building is surrounded by a very high fence and to reach the front door you must be buzzed into the interior parking lot by the control room staff. The exterior of the building is of brick construction and the interior is cinder block. There are 5 wings designated by letters on two floors. There is a full basement that is not accessible to the residents, so it was not toured. **A** wing, the Administrative area, has a public reception area with two bathrooms, a metal detector, control booth, two visiting rooms, Administrative offices, a training room, also used for visiting, and a chapel/multi-purpose room, where the PREA hotline is located and where interviews of staff and residents took place. The Intake Area is off the Administrative wing and has a separate drive up entrance/sally port. There is a shower/search bathroom, a laundry room, storage (not child accessible), and an Intake office area with built in counters where a PREA informational video is shown during Intake. B wing is comprised of a large gymnasium, 6 classrooms, and a cafeteria and kitchen. The art room is now a recreation room with an office for the Program Supervisor and pool tables and a pinball machine. Adjacent to B wing is a long hallway to E wing, which is in a "newer" wing, added on in the late 80's. E1 is the girls' unit and is at the end of the hall. You must knock and announce before entering and the windows in the entry door have been made opaque to limit viewing. You enter the unit into a common area, with a television and furniture and a large window wall directly across the room. To the right is a long hall with 12 separate individual rooms with a built in bed and toilet. Adjacent to the dayroom is a glass enclosed staff office with a staff bathroom. To the left of the office is one individual room and a laundry room. This individual room is used for either vulnerable or aggressive residents because it is completely separate from the other 12 rooms and receives more staff supervision.

The shower room opens into the common area and has three shower stalls and a bathtub, sink, and toilet. A door at the end of the hall, where the bedrooms are located, opens into a stairwell that is used for fire drills for this unit and for the unit above it, E2, a boys' unit. This stairwell is only used for fire drills and not for daily use. A stairwell on the first floor hall near the door to E1 is used for the boys and staff to access E2. This unit has the same physical layout (13 single rooms) as the unit below. It is used for boys who have achieved "gold" status and has more recreational items, such as video games in the day room. Through a long glass enclosed hall is C wing and D wing. C1 has 13 beds and a very similar layout to the previously described units. A small room directly off the hallway and next to the doorway is used by the nurse to dispense medication to the male residents. C2 is on the second floor above C1 and is currently not in use, except for an office with Video conferencing capability, used for the 72 hour Detention hearing and communication with the residents' public defenders. D1 is physically the same as the other units with 13 beds and a bathroom with three showers, a sink, toilet and tub. D2, on the second floor, is not used to house children; it is used as the "Medical Wing" and also houses caseworkers, mental health workers, a clinic for a mobile dentist and record keeping area. There are small examining rooms, where the residents can be seen privately. There is a fitness center with treadmills and other machines in one end of the wing. There are several recreational yards that are used by the children during nice weather and are inside the high fenced enclosure. There was a basketball court and several picnic tables under a large shade tree in the large courtyard. The facility has cameras in the hallways, dayrooms in the units, and common areas, as well as outside the building. These are monitored in the control room in A wing. Keys are used for some interior doors, whereas, you are buzzed in and out of exterior doors. All staff use walkie-talkies to communicate their whereabouts to the control room.

SUMMARY OF AUDIT FINDINGS

In summary, after reviewing all pertinent information provided to me prior to and during the onsite portion of the Audit, interviews with staff and residents, and the tour of the facility, it is apparent to this Auditor that the Facility Leadership and the Staff have spent considerable time and resources ensuring that the safety and security of these residents is the utmost priority. The culture of sexual safety and awareness was present during the first Audit, but is now more ingrained in the facility staff. This facility was Audited a little over two years ago. The record keeping and logs were exemplary.

The PREA Coordinator is the training supervisor and he is in this position temporarily having assumed the duties when the previous PREA Coordinator suddenly passed away. A new Assistant Director/PREA Coordinator will be promoted or hired in the next few months. The PREA Coordinator and the Director picked up all PREA related duties and followed through with the excellent record keeping and coordination of PREA at Delaware County Juvenile Detention. The staff and residents have demonstrated that they have not only received but understand the education and training.

There is an ongoing relationship and a MOU with Delaware County Women Against Rape (WAR) that allows for victim advocacy, emotional support and reporting. This agency is a member of PCAR, the Pennsylvania Coalition against Rape. There is an MOU with Riddle Hospital for Forensic Medical Examinations for Residents with SAFE/SANEs and there is a MOU with the Delaware County Criminal Investigation Division to conduct criminal investigations. This information is posted on the website.

The residents receive education at Intake. They look at a Power Point presentation which is age appropriate regarding Delco's Zero Tolerance Policy and how to report. Within 72 hours, the Caseworkers conduct the Vulnerability Assessment and the 10 day education which includes a review of Zero Tolerance and Reporting. Residents sign off on both the Intake and 10 day education. There are informational postings throughout the facility to act as ongoing education for both residents and staff. The PREA Coordinator conducts follow up education at 30, 60, and 90 days. This is a best practice and it was evident during the interviews that the children had been well educated.

The Vulnerability Assessments and the resultant medical and mental health follow ups are all done in a timely fashion for all admissions. The contract with the Child Guidance Clinic has put in place Master's Level Mental Health Therapists in-house conducting assessments for every admission as part of the Intake process. There is also an in-house contracted psychologist. I was provided with secondary documentation for those residents identified as perpetrators and/or who disclosed a prior victimization. Documentation of risk based housing is completed by the Caseworker who conducts the Vulnerability assessment and was being practiced.

All staff files were complete for both education/training, child abuse and criminal history clearances. All resident files, were complete for timely PREA education, administration of the VAI, necessary Medical and MH follow up and documentation of risk based housing decisions.

Three standards as noted below have been exceeded. Four standards as noted below do not apply. One standard requires corrective action. The remaining 33 Standards have been met. All policy and procedure meet the Standards. This report serves as the Interim Report. Ninety days of documentation needs to be submitted as noted in the corrective action plan for this facility to be fully compliant.

With the submission and review of the documentation for Standard #313, the plan of correction has been satisfied and the standard has been met. This facility is in full compliance with the PREA Standards, effective, 9-23-17.

The following standards have been exceeded:

Standard #333 Resident Education

The residents receive education at Intake. They look at a Power Point presentation which is age appropriate regarding Delco's Zero Tolerance Policy and how to report. Within 72 hours, the Caseworkers conduct the Vulnerability Assessment and the 10 day education which includes a review of Zero Tolerance and Reporting. Residents sign off on both the Intake and 10 day education. There are informational postings throughout the facility to act as ongoing education for both residents and staff. The PREA Coordinator conducts follow up education at 30, 60, and 90 days. This is a best practice and it was evident during the interviews that the children had been well educated.

Standard #351 Resident Reporting

Residents can report in writing, verbally, anonymously and through third parties. There is a "hotline" to WAR, a PCAR, who accepts reports. This hotline is in the chapel. You pick up the receiver and it automatically dials to WAR. I did so and it worked as described. There are posters next to the phone declaring it a hotline. Pencil and paper are available as seen on the tour. There is a PREA Box with reporting forms next to it on every living unit. I saw a video of an unannounced round being conducted on the midnight shift and the Administrator checked the PREA Box. There is a grievance form and procedure given to each resident. The residents have private and confidential access to attorneys, parents, guardians, probation officers and children and youth caseworkers through phone calls and visiting. Interviews with 10 random residents showed that they were aware of these reporting avenues. Most of them stated they could tell staff or a parent, but all

knew of the “hotline”. The staff that were interviewed all knew of the various ways both they and the residents could report. The residents are advised of these avenues at Intake. There are reporting posters in Spanish and English throughout the facility. Every possible avenue has been afforded for reporting and so this standard has been exceeded.

Standard #381 Medical and Mental Health Screenings

All admissions receive a Medical and Mental Health Screening at Intake conducted by a nurse and a Master’s Level Mental Health Caseworker contracted through the Child Guidance Clinic. A physical is conducted by a doctor within 72 hours of Intake. All residents are screened by an adolescent health specialist for STD testing and education and all girls are screened for pregnancy. This occurs within the first week for all residents. This is a best practice and for this reason, this standard has been exceeded.

The following standard requires Corrective Action: Standard #313: Monitoring and Supervision

All provisions of this standard were met except for the provision requiring random unannounced rounds conducted by upper and mid level supervisors on all shifts. Although documentation was provided to me and I saw a video of an unannounced round occurring on a midnight shift, there were not sufficient midnight rounds conducted at all hours. Ninety days of documentation of random rounds being conducted at all hours on all shifts needs to be submitted to the Auditor in order for the facility to be in compliance with this standard.

On 9-13-17, I received logs of unannounced rounds for July, August and September of 2017. These rounds were conducted by the Director and the PREA Coordinator and occurred on all three shifts and at different times. These rounds also occurred on weekends. This documentation satisfies the plan of correction and this standard has been met.

Effective 9-23-17, this facility is in full compliance with the PREA Standards.

The following standards do not apply:

Standard #312: Contracting with other entities for confinement of residents: Delaware County does not contract with any other entities for the confinement of their residents.

Standard #318: Upgrades to Facilities and Technology: There have been no upgrades since the prior Audit.

Standard #334: Specialized Training; Investigations: Delaware County Juvenile Detention staff do not conduct Investigations. This is done by Delaware County CID and Pa. Department of Human Services Child Line.

Standard #368 Post Allegation Protective Custody: The Pa. 3800 Child Care Regulations prohibits the use of Isolation. Isolation is not practiced at Delaware County Juvenile Detention.

Number of standards exceeded: 3

Number of standards met: 34

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.

Documentation Reviewed:
Zero Tolerance Policy
Delaware County Organizational Chart
Interviews Conducted:
PREA Coordinator

The review of the policy and the organizational chart and the interview of the PREA Coordinator show that he has sufficient time and the authority to coordinate the facility's PREA compliance efforts. The organizational chart confirms that he has the authority within the organization to ensure compliance. The PREA coordinator on the organizational chart is the Assistant Director. During this Audit, the Training Supervisor assumed the role of the PREA Coordinator due to the Assistant Director's untimely passing. A new Assistant Director/PREA Coordinator will be hired in the next few months. The Training Supervisor, who I interviewed along with the Facility Director, assumed all PREA related responsibilities. The Training Supervisor had worked with the PREA Coordinator to train staff and implement policy.
The PREA Zero Tolerance Policy contains definitions of sexual abuse and sexual harassment and procedures regarding preventing, detecting, reporting and responding to sexual abuse and sexual harassment. The policy dictates how these procedures will be implemented. This standard has been met. There is no need for corrective action.

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 standard does not apply. The facility does not contract with any other agency or facility to provide confinement for their residents

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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.

Documentation Reviewed:

Pa. Bureau of Human Services 3800 Child Care Regulations
Pa. Bureau of Human Services Licensing and Inspection Summary
Posted Staff Schedules
PREA Zero Tolerance Policy
Logs of Unannounced Rounds
Documentation of yearly review of staff schedules by PREA Coordinator
Video of Random Unannounced Round conducted on Friday, 6-16-17 at 1:45 AM
Logs of Additional Rounds conducted in July, August and September 2017

Interviews:

PREA Coordinator
Facility Director
Residents during tour
Staff during tour

The review of the Zero Tolerance Policy, Delaware County policies and the above documentation shows compliance with staffing, supervision, and ratio. The policy takes into account all eleven of the criteria in the standard. There have been no instances of not meeting ratio and this is confirmed by interview and by review of the most recent Pa. Bureau of Human Services Licensing and Inspection Summary. The Pa. BHSL inspects staffing during their annual licensing inspection and throughout the year if there is a reportable incident.
I reviewed documentation of yearly review of staffing by the PREA Coordinator. The PREA Coordinator reviews staffing on a yearly basis as required. The PREA Coordinator states that staffing is reviewed daily to ensure one on one supervision and that other resident needs are met.
The ratio that is required by the Pa. 3800 Child Care regulations is 1:6, 1:12 because this is a Secure Detention facility. The Director states his ratios are usually better than that.
I was provided current staff schedules with more than the required ratio. They are completed weekly and are kept in the control room log book. The use of voluntary and, if needed, mandatory overtime provides for any emergency staffing, so there are never any deviations. The Director stated if they have a particularly aggressive resident, an extra staff will be added to that unit. Just as recently as last week, the facility conducted a field day in the courtyard. Additional staff were called in to properly supervise this event.
During the tour, I saw residents supervised in groups at breakfast and in each living unit.
Prior to the onsite, I was provided logs of unannounced rounds conducted by both the Facility Supervisor and the PREA Coordinator. I was provided with additional logs during the onsite. The Facility Director conducts them on all shifts and documents them. He never advises anyone that he will be conducting a round to prevent staff from alerting other staff. This is also prohibited in policy. He uses a different door every time and carries a walkie talkie to ensure that staff are not alerting other staff. The PREA Coordinator also conducts rounds. The logs document that random unannounced rounds are being conducted on all shifts. I reviewed a video of an unannounced round being conducted on Friday, June 16, 2017 at 1:45 AM, a midnight shift. Although the rounds are occurring on all shifts, they are not occurring frequently or randomly enough on midnight shifts.
Corrective Action:
Ninety days of documentation of random unannounced rounds by mid and upper level supervisors occurring at all hours on all three shifts needs to be submitted to the Auditor to be in compliance with this standard.
On 9-13-17, I received and reviewed documentation of random unannounced rounds for July, August, and September 2017. They were conducted by the Director and the PREA Coordinator on all three shifts, at all hours and on weekends. This documentation satisfies the plan of correction and 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.

Documents Reviewed:
Zero Tolerance Policy
Search Policy
Shower Policy
Gender Variant Search Preference Form
Staff Training Curriculum
Staff Training Logs
Interviews:
10 staff
10 Random residents

The Delaware County Zero Tolerance Policy contains the necessary requirements for this standard. It, along with the Detention Search policy, prohibits any kind of cross gender search including cross gender pat down searches. The policy also prohibits the search or physical examination of a Transgender or Intersex resident for the sole purpose of determining that resident's genital status. There have been no cross gender searches of any kind. Staff state they do not conduct them and some staff stated that even in an emergency they believe that a same sex staff would conduct a pat down search. Residents state that they have never been subject to a cross gender pat down search. All staff have received training regarding the search of a Transgender or Intersex resident in a respectful and dignified manner.
Although there were no transgender or intersex residents in the current population, a transgender girl was admitted within the past 12 months. I saw documentation that she was housed on a female unit and that all pat down searches were conducted by female staff.
Staff and residents both state that staff practice "knock and announce" when entering a housing unit that houses residents of the opposite gender. Both staff and residents could demonstrate this for me. I saw posters at the door of every wing and I saw "knock and announce" practiced during the tour. Residents state that they always shower alone. The bathrooms contain single showers with a curtain. Same sex staff conduct showers.
All residents can shower, toilet, change clothes and perform bodily functions without being viewed by staff of the opposite sex according to interviews of both staff and residents.
This standard has been met. There is no need for corrective action.

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.

Documents Reviewed:
Zero Tolerance Policy
Spanish and English Reporting Posters
County Language Access Phone, Interpretive Services
Interviews Conducted:
Facility Director
Ten Staff

During the Audit, there were no residents who were disabled or who were not English proficient. During the tour, I saw all postings in Spanish and English. The County has a "Language Access Hotline" that includes translators and resources for those that are deaf or blind.

The Director stated that all reasonable accommodations would be made for a resident with a disability. There is the capacity through the Educational program, the Delaware County Intermediate Unit, for all residents to receive PREA Education.
The PREA policy requires these accommodations.
This standard has been met. There is no need for corrective action.

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.

Documentation Reviewed:

Pa. Department of Human Services 3800 Child Care Regulations
Pa. Bureau of Human Services Licensing and Inspection Summary
Pa. Child Protective Services Law
Zero Tolerance Policy
Files of 11 staff including one who had been recently hired
File of one Contractor

Interviews:

Training Director/PREA Coordinator

The Zero Tolerance Policy and the Pa. Child Protective Services Law require Criminal History Checks, FBI clearances, and Child Abuse Checks for employees and contractors prior to employment. The policy requires a continuing affirmative duty to report prohibited conduct and this information is requested on the employment application and in interviews. There is Zero Tolerance for this behavior when seeking a promotion within Delaware County.
The Pa. Child Protective Services Law requires these clearances prior to employment and all new employee files are inspected during the annual licensing inspection as well as those of contractors and volunteers. A percentage of random employee files are inspected by BHSL as well. There have been no citations for non-compliance in this area.
I checked the files of 11 staff, including one who had most recently been hired and one contractor, and all had the required clearances. There have been no recent promotions.
The policy and the interview with the PREA Coordinator who conducts employment interviews reveal that a Criminal History check, Child Abuse Clearance and FBI clearance of all employees will be conducted every five years. I saw timely re-checks in all 8 employee files that require them.
This standard has been met. There is no need for corrective action.

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.

This Standard does not apply. Both the tour of the facility and the interviews with the PREA Coordinator and the Facility Supervisor confirm that there has been no renovation, expansion or modification to the facility and no installation or upgrade of the camera system.

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.

Documents Reviewed:

Zero Tolerance Policy
MOU with Riddle Memorial Hospital
MOU with WAR
MOU with Delaware County Criminal Investigation Division

Interviews:

PREA Coordinator
Nurse
10 Staff
Phone Interview with Director of WAR (a PCAR) prior to onsite

The PREA Zero Tolerance Policy contains all necessary provisions to meet this standard. MOUs are in place for the hospital, Riddle Hospital, to provide forensic medical exams with a SAFE/SANE. Investigations are conducted by Delaware County CID and their responsibilities are outlined in the MOU. WAR, a member of the Pennsylvania Commission Against Rape (PCAR), provides a victim advocate and crisis intervention, emotional support, information and referrals.
I spoke to the Director of WAR prior to the onsite portion of the Audit by telephone and she confirmed the services stated in the MOU. All MOUs are in place for the necessary services to be offered for a resident outside of Detention.
The Nurse confirmed SAFE/SANEs at Riddle Hospital.
There were no residents to interview who reported a sexual abuse. There have been no incidents of sexual abuse in the past 12 months. This standard has been met. There is no need for corrective action.

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.

Documents Reviewed:

PREA Zero Tolerance Policy
Pennsylvania Child Protective Services Law (CPSL)
Delaware County Juvenile Detention website
MOU with Delaware County CID
Reports of Unfounded Staff on Resident Sexual Harassment.

Interviews:

Facility Director

I interviewed the Facility Director and reviewed the PREA Policy and the MOU with Delaware County CID. All policies and procedures required by both PREA and the Pa. Child Protective Services Law are in place. The Director states that all incidents are reported and documented. I also verified that the website includes the fact that all allegations are reported to the Delaware County CID and Pa. Child Line. Detention staff do not investigate allegations but report all of them. The contact information for Pa. Child Line and Delaware County CID is on the website.

There was one allegation of a sexual harassment by a staff against a resident. The resident used the hotline to WAR to report it. The facility reported it to Child Line and they deemed it unfounded. All documentation demonstrated timely adherence to the reporting policy.

This standard has been met. There is no need for corrective action.

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.

Documents Reviewed:

PREA Policy
PREA Curriculum for Employees
Mandated Reporter Curriculum
Pa. Dept. of Human Services 3800 Child Care Regulations
Eleven Random employee files

Interviews:

PREA Coordinator
Ten Staff

I reviewed the PREA Zero Tolerance Policy which requires all staff to receive PREA Training. Existing staff received it when PREA was first implemented in 2014 and any staff who were hired after that date receive this training during orientation. The staff receive training every year. I saw sign in sheets for all staff training and I saw certificates that they had completed the training in a log book. On the back of the certificate is a check off list and signature page completed by staff, demonstrating receipt and understanding of the training. The log is divided by department, i.e. kitchen, medical. I reviewed 10 random staff files to ensure yearly training that is appropriate. All staff reviewed had received initial and refresher training.

The training includes how to detect, prevent, report and respond to allegations of sexual abuse and sexual harassment according to the agencies policies and procedures. The ten random staff who were interviewed were able to candidly discuss their training which included signs and symptoms of sexual harassment victims, the dynamics of sexual abuse in a confinement setting, how to avoid inappropriate interactions with residents, how to interact with all residents in a respectful and professional manner, including those who may identify as LGBTI. All staff could tell me they received initial training and annual refresher training as recently as last week. One staff who was interviewed stated that "staff boundaries" is an important part of their training.

All line staff also receive mandated reporter training as per the Pa. Department of Human Services 3800 Child Care Regulations and they were able to discuss their mandated reporter responsibilities as well as their first responder responsibilities.

The training contains all provisions and the review of files showed all staff receive it and the interviews demonstrate that staff understand it.

This standard has been met. There is no corrective action needed.

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.

Documents Reviewed:

Zero Tolerance Policy
PREA Brochure for Contractors
PREA Power Point for Volunteers and Contractors
Training Logs
Signed Training Acknowledgement of a Contracted Employee
Signed Training Acknowledgement by a Volunteer

Interviews:

Contracted Employee , the psychologist
Volunteer, Yoga instructor

I conducted an interview with a Contracted Employee, the psychologist. He was able to tell me that he received training and the extent of the training. He was able to tell me that he would report to his immediate supervisor and would also document the report. He is a mandated reporter by law and has receive the mandated reporter training. A contractor receives a PREA brochure or the PREA power point presentation depending upon level of interaction that describes the Zero Tolerance Policy. I saw the signed acknowledgement of training for the contractor.

The Yoga instructor, who works for the "Transformation Yoga Project.org", is a volunteer who has been teaching yoga to the residents on a voluntary basis for the past two years. She stated that she received training that includes "Professional Boundaries", "reporting", and "signs to look for". She states that she would immediately report to the training supervisor or she could use the PREA box. I saw her signed acknowledgement of training.

I saw a log of all volunteer and contractor training and their signed acknowledgements.

This standard has been met. There is no need for corrective action.

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.

Documents Reviewed:

PREA Zero Tolerance Policy
PREA Orientation Power Point

Resident PREA Orientation Acknowledgement Form
Posters for Reporting and Education in Spanish and English
Resident 10 day Education sign offs
Resident 30/60/90 day Education sign offs
12 Resident Files (10 active and two discharges)

Interviews:

Staff person who performs Intake
Caseworker who performs 10 day Education
PREA Coordinator who performs 30/60/90 day education
10 random residents.

This facility conducts education as a two part process. I interviewed the Admission's staff who performs Intake education. He stated that he conducts Intake education "as soon as they walk through the door". There is an Intake Power Point in both Spanish and English. It is Delaware County specific and age appropriate. The Intake staff states that he explains PREA to residents and "I ask them if they have any questions". He gives them a brochure with the same information and they sign off that they have received this education and it becomes part of their file. The 10 day education is conducted by a caseworker within 72 hours. It is conducted during the Vulnerability Assessment process. The education is a check list with each item initialed by the residents. I saw signed acknowledgements of education in all 12 files. All education was done in a timely fashion.
The PREA Coordinator conducts re-education at the 30, 60, 90 day mark. I saw a file of a resident who had three sign offs in his file because he had been there over 90 days. Most residents are there on average of 11 days because this is a short term Detention facility. There are reporting posters throughout the facility.
All residents could tell me that they received education upon admission. Several residents had PREA education several times because they had been admitted several times. One female resident told me she could teach PREA because she had it so often. Most residents could also tell me about services offered outside of the facility through WAR because of the posters with phone numbers and addresses.
Due to the comprehensive education and frequent re-education this standard has been exceeded.
There is no need for corrective action.

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.

This standard does not apply. There are no investigators at this facility.

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.

Documents Reviewed
PREA Policy
Employee Training Curricula
NIC Specialized Medical Training Online Curriculum
Training Logs
Certificates of Completion of NIC Medical Training
Interviews:
Nurse
Master's Level Mental Health Caseworker

This facility does not perform any forensic medical examinations. These are conducted at Riddle Hospital by SAFE/SANEs and there is a MOU with the Hospital.
I interviewed a full time Nurse and I also interviewed a Master's Level Mental Health Caseworker contracted through the Child Guidance Clinic. Both have completed the online NIC PREA Training and the training for all staff. They both received Mandated Reporter training and would report to Child Line and their immediate supervisor as well as document any allegation of abuse.The Mental Health Caseworker has received extensive training through her education; she is a doctoral student and has had education that includes trauma based care. The Nurse states that in addition to the above training she has received sexual abuse training at Crozier Hospital and Child Abuse Training through the University of Pittsburgh. Both state that forensic examinations are not conducted at the Detention Center and that they both have received training regarding the sexual abuse of juvenile victims. They have both received training on the protection of forensic evidence.
I received certificates of completion for the NIC PREA online course for all Medical and Mental Health emloyees. They were also on the employee training log for having completed the education that all employees receive.
This standard has been met. There is no need for corrective action.

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.

Documents Reviewed:
PREA Zero Tolerance Policy
Vulnerability Assessment Instrument
Completed Vulnerability Assessment Instruments for 12 Residents (10 Active, 2 discharges)
Gender Variant Search Form
Interviews:
PREA Coordinator
Case manager who completes Vulnerability Assessment

The Vulnerability Assessment Instrument is a commonly used one that takes into account many variables including: age, physical size and appearance, physical or mental disabilities, prior victimization, charges, LGBTI identification, Mental illness, socialization issues, emotional issues, and the resident's own perception of vulnerability.
The staff who administer the instrument, the Caseworkers, take into account the Intake packet, conversations with parents, probation officers and caseworkers, and the psychosocial evaluation that is completed by the Child Guidance Center staff as part of every Intake. The Case Manager who was interviewed uses the VAI as a guideline and uses a combination of developing a conversational rapport with the resident and asking direct questions. She is also conducting the 10 day education at the same time and uses the education as a way to elicit sensitive information.

All competed VAIs are part of the residents' records and have restricted access. Only the administrative staff, Nurse, Child guidance staff and the caseworkers have access to these files. The necessary information to keep a child safe is placed on the housing log, e.g. "SA" (shower alone). I reviewed the files of 12 residents (10 active and 2 discharged). I chose two files randomly from those admitted during the past 12 months and reviewed the active files of those residents that were interviewed. All had timely administration of the VAI. One of the 12 files reviewed required 30/60/90 day re-assessments per policy and they were conducted in a timely fashion.
I also requested and saw a Vulnerability Assessment conducted on a Transgender girl in the last 12 months. It was completed according to policy and the follow up housing and gender variant search were completed according to policy as well.
I interviewed 10 residents and all could state that they were asked questions when they first arrived as to whether they had ever been sexually abused, if they had any disabilities or if they were fearful of sexual abuse at the facility.
This Standard has been met. There is no need for corrective action.

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.

Documents Reviewed:
PREA Zero Tolerance Policy
Pa. Department of Human Services 3800 Child Care Regulations
Shower Policy
Housing Logs
Vulnerability Assessments of 12 residents (10 active, 2 discharges)
Interviews:
PREA Coordinator
Case Manager who conducts Risk Screening

Isolation is not practiced and is prohibited by both the Delaware County Juvenile Detention Policy and by the Pa. Department of Human Services 3800 Child Care Regulations.
I interviewed the above staff who state that any resident who is identified as either vulnerable or aggressive on the risk screening is considered for housing in a room that would protect either that resident or the other residents. While on the tour, I observed this single room, which is separate from the other rooms and across from the staff office. I also observed the bathrooms that have three single shower stalls with curtains. The girl's shower room also has a bathtub which is in an alcove in the bathroom. Any resident who expresses a desire can be placed on Shower Alone status. I saw this "SA" abbreviation on the current census next to some childrens' names.
The staff state that there are no specific or segregated housing units for LGBTI residents. Transgender or Intersex resident housing would be determined on a case by case basis and would be formally reviewed every thirty days and most probably daily. The residents own views for their safety would be taken into account when making housing decisions as well as the safety and security of all the residents. A LGBTI resident is never identified as sexually aggressive based solely on their LGBTI status. There were no Transgender or Intersex residents in the population during the Audit. However there had been a Transgender girl who was admitted during the past 12 months and a review of her file showed that she was placed on the female unit at her request. I interviewed one resident who self-identified as Gay in the population at the time of the onsite. She stated she was not discriminated against in any way.
I reviewed the files of 12 residents (10 active and 2 discharges). Three residents were identified as sexually aggressive and there was a risk based housing sheet in their files. The housing logs documented their housing. There were no residents who identified as sexually vulnerable, but an 11 year old in the population was noted as requiring extra supervision because of his age.
The policy contains all necessary verbiage and according to the interviews the policy is in practice.
This standard has been met and no corrective action is necessary.

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.

Documents Reviewed;

PREA Zero Tolerance Policy
Grievance Policy
Telephone Policy
Visiting Policy
Pa.Child Protective Services Law
Pa. Bureau of Human Services 3800 Child Care Regulations
Resident Rights' Form
MOU with WAR

Interviews:

PREA Coordinator
Director of WAR, a PCAR (by phone, prior to Audit)
Ten Staff
Ten Random Residents

I reviewed the PREA Zero Tolerance Policy and it contains all necessary information and provides for residents to make reports verbally, in writing, anonymously and through third parties. It mandates that staff accept resident reports in all these formats and that they document and report to Pa. Child Line and their supervisors immediately. All residents and staff interviewed were able to tell me at least two ways a report could be made and most were able to tell me many other ways that a report could be made.

The primary reporting mechanism is to an outside agency, WAR. There is an MOU with this agency and this "hotline" allows for receipt of the report and transmission to the facility anonymously if requested. Prior to the onsite, I conducted a telephone interview with the Director of WAR and she confirmed the services outlined in the MOU. This reporting method is posted throughout the center. The private "hotline" is located in the chapel. When you pick up the receiver, it dials directly to WAR. I did this while on the tour and it worked as directed. There is a PREA Box in every living unit with reporting slips next to it. It is a locked box and is checked daily by the PREA Coordinator and/or Director. On the video of the midnight round, I saw the PREA Coordinator checking the PREA box. The residents can also call Child Line and the staff must call Child Line as mandated reporters.

The Pa. Department of Human Services 3800 Child Care Regulations require a Grievance Policy and that all residents and their parents receive it and acknowledge it. This is another avenue for reporting and is contained in every child's file and is audited by PA. BHSL.

Residents can also call home every day if they "have money on the phone" and at least once a week if they do not have money on the phone account. Residents can also receive visits from parents and grandparents twice a week and special accommodations can be made for parents who live far away or who work during regular visiting times. Visits by Probation Officers, Caseworkers, and Attorneys are not limited and residents confirm they receive them.

Every possible avenue has been provided for residents to confidentially report sexual abuse, harassment or retaliation. All staff and residents were able to provide me with at least two avenues.

This standard has been exceeded. No corrective action is needed.

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.

Documents Reviewed:

PREA Policy
Grievance Policy
Pa. Department of Human Services 3800 Child Care Regulations
Pa. Bureau of Human Service Licensing Annual Licensing and Inspection Summary
Child's Rights' Form
Grievance Form
Files of 12 residents (10 Active, 2 discharges)

Interviews Conducted:

PREA Coordintor

There were no incidents of sexual abuse, sexual harassment or retaliation filed using grievances in the past 12 months. No grievances by residents or third parties were filed alleging sexual abuse, harassment or retaliation. The Policy provides that grievances can be used to report sexual abuse or harassment, but residents are not required to use a grievance. If they do, they can do so without having to submit or refer to the staff involved in the grievance. The timelines for the resolution of the grievance are outlined in the policy and are within 48 hours if it is an emergency grievance. Residents cannot be disciplined for filing a grievance.
The Pa. Department of Human Services 3800 regulations require a grievance policy and notification and acknowledgement of such by both the resident and their parent/guardian. The Pa. BHSL, during their annual licensing inspection, inspects resident files for this signed acknowledgement by both parent and resident. I reviewed 12 resident files and all contained notification of the grievance process. Additionally, the most recent Licensing and Inspection Summary contained no citations for failing to follow the grievance process.
The grievance process was not mentioned as often as the "hotline" or "telling a staff" by either residents or staff interviewed, but it is available to all residents.
This standard has been met and does not require corrective action.

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.

Documents Reviewed:

PREA Policy
Visiting Policy
Telephone Policy
Spanish and English Posters for WAR in the Facility
Resident PREA Intake Brochures
MOU with WAR

Interviews:

PREA Coordinator
Ten Random residents
WAR Director (by phone prior to onsite)

The PREA Policy outlines that the Youth Center will provide residents with access to confidential emotional support services through WAR. Posters in both Spanish and English are posted throughout the facility with the name, phone number and address for this service. The education that the residents receive at different intervals throughout their stay also includes what services are offered and how to contact this agency to access these services.
The PREA Coordinator described the MOU with WAR, a PCAR, and the services that they offer. The MOU was reviewed and I spoke to the WAR Director by telephone prior to the Audit to confirm the services offered in the MOU.
The residents who were interviewed state that they can make and receive phone calls at least once a week and many can use the phone every day. Visiting by parents/grandparents/guardians is twice a week and accomodations will be made for those parents who cannot come during regular visiting hours. If a resident is going to placement, the facility allows visiting with extended family including siblings before they are discharged.
Probation officers, caseworkers, and attorneys are not subject to the visiting or telephone policy and can visit when it is convenient. The residents that were interviewed state that they usually see the Public Defender before Court and can call their lawyer through their caseworker.
Most residents were able to tell me about the counseling services offered through WAR because the information was on posters and the brochure they had received at Intake. Two residents were unable to tell me about the services; one because he was 11 years old and the other because he was not cooperative. I directed them to the poster in the room we were in.
This standard has been met and requires no corrective action.

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.

Documents Reviewed:

PREA Policy
Delaware County Juvenile Detention Center website

The policy requires Third party reporting avenues. This information on how to report is publicly disseminated by the facility via the website, which was verified, and it is also posted in the facility in the area where parents and guardians visit. In the public waiting area in the front lobby, there are PREA reporting forms and an actual mailbox with PREA on it for reporting.
This standard has been met and requires no corrective action.

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.

Documents Reviewed:

PREA Policy
Pa. Child Protective Services Law
Training Logs
Pa. Department of Human Services 3800 Residential Child Care Regulations
Documentation of Reports of Unfounded Sexual Harassment

Interviews:

Facility Director
PREA Coordinator
Ten Staff
Nurse
Mental Health Caseworker

There have been no incidents or reports of sexual abuse and one unfounded report of sexual harassment in the past 12 months. The PREA policy, as well as the Pennsylvania Child Protective Services Act, requires that all staff immediately report any knowledge or suspicion of sexual abuse, sexual harassment, or retaliation. All staff are mandated reporters. All staff receive mandated reporter training as per the Pa. DHS 3800 Residential Child Care Regulations. All staff interviewed knew that they must report to Pa. Child Line under penalty of Law. The two Medical staff interviewed are also mandated reporters. They stated during their interviews that they report to Pa. Child Line and their supervisor. The also would document any report received. The psychologist who was interviewed is a mandated reporter.
The Director states that the PA. 3800 Child Care regulations require a report within 24 hours, documenting notification of the parent, guardian, probation officer, caseworker and court. The Director states that if there is an attorney of record, they would also be notified and if there was a court order prohibiting a parent from notification, they would contact a guardian.
This was done for the unfounded allegation of sexual harassment and this documentation was provided to me.
This standard has been met and there is no need for corrective action.

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.

Documents Reviewed:

PREA Zero Tolerance policy

Interviews:

Facility Director
PREA Coordinator
Ten staff

There have been no incidents in the past twelve months where a resident was at substantial risk of imminent sexual abuse.
After reviewing the policy and interviewing the 10 random staff, the PREA Coordinator and Facility Director, I believe that any report of imminent sexual abuse would be handled immediately and properly as outlined in the policy and required by the Standard.
This standard has been met. There is no corrective action necessary.

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.

Documents Reviewed:
PREA Policy
Pa. Child Protective Services Law
Interview:
Director

There have been no incidents that have required reports within the past twelve months.
The policy clearly states that if a resident reports a sexual abuse at another facility to a staff person, it will be reported to Child Line and documented. The Director or PREA Coordinator will notify the Director at the facility where the alleged abuse occurred and will document that notification. This will occur within 24 hours.
If a report is made at another facility regarding an allegation against Delco staff, it will be reported to the Director or PREA Coordinator who will contact Child Line and Delaware County CID and will document within 24 hours of receiving the report. All other parties, parents, guardians, POs, and caseworkers will also be notified within 24 hours.
This standard has been met. There is no need for corrective action

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.

Documents Reviewed:
PREA Policy
Interviews:
Ten Staff

There have been no incidents in the past twelve months that have required first responder actions.
The policy contains the following first responder duties: seek assistance, separate the victims, secure the scene, report to your supervisor document and contact the medical department. This is contained in the staff training curriculum. When interviewed, the ten random staff were able to discuss their first responder duties although they have not had to practice them.
The policy also contains the provision that, if a first responder is not a child care staff, they are to protect the scene and immediately notify a child care staff.
This standard has been met. There is no need for corrective action.

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.

Documents Reviewed:
PREA policy
Sexual Abuse Checklist
Interviews:
Facility Director

There have been no incidents in the past twelve months that have required the use of the Coordinated Response. The Facility Director stated during his interview that, although not utilized for a report of sexual abuse, it is and has been used for other types of incidents, demonstrating that the policy is in practice. There is a sexual assault checklist that requires the staff person to check off each item such as notifications of medical, administration, documentation etc.
This standard has been met. There is no need for corrective action.

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.

Documents Reviewed:
PREA Policy
Pa. Child Protective Services Law
Union Contract with AFSCME DC 88
Interviews:
Facility Director

AFCSME DC 88 is the Union representing the Juvenile Detention staff and a new contract has just been signed. There is nothing in the contract that prohibits the facility from removing an employee from contact with a resident who alleges sexual abuse or sexual harassment. This is also included in the PREA Zero Tolerance Policy.
An interview with the Director reveals that any time there is an allegation, a plan of safety for the specific resident and all the residents is put into place and this always includes removing the staff person from contact with the resident or residents depending upon the allegation. This is required by the Pa. CPSL.
This standard has been met. There is no corrective action that is needed.

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.

Documents Reviewed:
PREA Policy
Interviews:
PREA Coordinator

There have been no incidents that have required monitoring for retaliation. However, the PREA Coordinator checked in every day with the resident who alleged sexual harassment by staff even though it was unfounded.
The PREA policy requires that a staff person monitor retaliation of anyone who reports an incident of sexual abuse or cooperates in the investigation. The staff person charged with monitoring retaliation at this facility is the PREA Coordinator. He states that he would monitor retaliation against a resident or staff by contacting them immediately and telling them if they receive any threats from anyone they are to contact him immediately. He would also do a status check daily if needed and would do so for length of stay, which in most cases is shorter than the 90 days in policy, because the average length of stay is 11 days. He monitors changes in residents, including changes in behavior, write ups that are not warranted, and withdrawal from activities. He would monitor work records of staff, including tardiness, and absenteeism, among other variables.
He stated that anytime there is a report of sexual abuse, whether it is resident on resident or staff on resident, the Pa. 3800 child care regulations require a safety plan which includes separation of the alleged perpetrator and victim. This could include changing a staff''s work assignment or suspension. It could include moving the child's room, unit or program. Any such incident requires a Safety Plan.
In the case of staff, he would probably include Human Resources and this could include emotional support or disciplinary action.
The PREA Coordinator stated that he did a status check every day with the resident who alleged the unfounded sexual harassment. This standard has been met. There is no need for corrective action.

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.

Documents Reviewed:
PREA Policy
Interviews:
Facility Director

This standard does not apply. There is no 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.

Documents Reviewed:
PREA Policy
MOU with Delaware County CID
Pa. Child Protective Services Law
Interviews:
Facility Director
PREA Coordinator

There have been no sexual abuse and one unfounded sexual harassment reports within the past twelve months. The PREA Policy contains all necessary verbiage and provisions, however most of the sub-standards are the jurisdiction of the investigating agency, Delaware County CID, with whom the facility has a MOU. The facility does not conduct criminal or administrative investigations. Reports are made to law enforcement and Pa. Child Line. By law, the facility may not conduct or interfere with an investigation. Both the PREA Coordinator and the Facility Director state that they have a very cooperative relationship with Delco CID.
The facility would gather enough information to report and to institute a safety plan as required by the Pa. 3800 child care regulations and the Delaware County Juvenile Detention Coordinated Response. An Incident Review would also be conducted after the investigation was completed.
By law, the facility reports all allegations, even if the victim has recanted. All allegations, whether by a resident or staff, are properly reported. All allegations, even if a staff person is no longer employed at the facility, are reported.
The policy meets the standard and no corrective action is needed.

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.

Documents Reviewed:
PREA Policy

The Standard of Proof is in the PREA policy, however this facility does not conduct investigations, nor do they substantiate allegations of sexual abuse. This is the jurisdiction of Pa. Child Line and Law Enforcement.
This standard has been met. There is no need for corrective action.

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.

Documents Reviewed:
PREA Policy
Pa. Department of Human Services 3800 Child Care Regulations
Interviews:
Director

The PREA Policy requires the facility to notify the resident and the parent/guardian of the status of the report and to whom it has been reported. The required Safety Plan, under the Pa. 3800 Child Care regulations, describes how the victim and other residents will be kept separate from the staff alleged to have committed the abuse. The Director stated that the resident would be continually informed as to the ongoing status of the investigation, whether it was resident on resident or staff on resident. He states that Pa. Child Line notifies the resident, parent/guardian, and the facility upon the completion of the investigation of the outcome. If Child Line is not involved, the facility would notify the resident and parent and would document the notification.
There have been no reports of sexual abuse in the past 12 months.
Although there have been no incidents to demonstrate compliance, I feel that the policy and the interview confirm that the standard would be met.
There is no corrective action needed.

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.

Documents Reviewed:
PREA Policy
Pa. Child Protective Services Law
Interviews:
Facility Director

There have been no incidents within the past twelve months that have required staff discipline for sexual abuse or sexual harassment.
The policy includes all provisions including discipline commensurate with the nature and severity of the incident. Termination is the presumptive discipline for a founded Child Abuse. A staff person may have no contact with children if they have an indicated or founded Child Abuse report. All acts that are criminal in nature are reported, even if a staff person resigns or is no longer employed.
This standard has been met and needs no corrective action.

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.

Documents Reviewed:
PREA Policy
Pa. Child Protective Services Law
Interviews:
Facility Director

There have been no incidents of this nature in the past twelve months. Both the PREA Policy and the Pa. CPSL prohibit contact with residents if a contractor or volunteer has a founded or indicated child abuse. The Facility Director states that he would prohibit a volunteer or contractor from entering the facility if they violated the facility zero tolerance policy. If the incident rose to a criminal level, it would be reported to Pa. Child Line and Law Enforcement. He also states he would contact the contractor or volunteer's agency.
The policy and the interview confirm that this standard is met. No corrective action is needed.

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.

Documents Reviewed:
PREA Policy
Pa. Child Protective Services Law
Pa. Department of Human Services 3800 Child Care regulations.
Interviews:
Facility Director
Nurse
Mental Health Caseworker

There have been no incidents of resident discipline for violation of the Zero Tolerance Policy in the past twelve months. The PREA Policy requires a formal disciplinary process for any child in violation of the agency's zero tolerance policy. The facility prohibits any sexual activity between residents or between residents and staff. The Pa. Department of Human Services 3800 Child Care regulations prohibits sexual activity between residents, however, if it is consensual, it is not reported as sexual abuse.
Any report made by a resident in good faith cannot be disciplined according to PREA Policy and the Pa. CPSL. The resident who reported the unfounded allegation of sexual harassment was not disciplined.
The PREA policy prohibits discipline of a resident for sexual activity with a staff person, unless the staff person did not consent.
The Director states that the only sanctions for a violation of the policy are reduction in level. Isolation is prohibited by regulation. No other discipline is allowed and he states that age, mental illness or disability would be taken into account on a case by case basis for all residents.

Both the Nurse and the Mental Health Caseworker state that counseling would be offered to both the victim and the perpetrator, but it is voluntary and a resident would not be prohibited from program or educational participation.
This standard has been met. There is no corrective action needed.

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.

Documents Reviewed:
PREA Policy
Vulnerability Assessment Instrument
Logs of all Admissions from 6-1-16 through 6-20-17
Secondary Medical Documentation
Files of 12 residents (10 active, 2 discharges)
Interviews:
Case Manager who administers Risk Assessment
PREA Coordinator
Nurse
Mental Health Caseworker

The policy requires Medical or Mental health follow up within 14 days of disclosure for any resident who discloses a prior sexual abuse. The policy also requires a mental health follow up by a Mental health professional for any resident who has previously perpetrated a sexual abuse. The policy and practice require every resident who is admitted to be seen by the Nurse upon admission and also the Master's Level Mental Health Therapist from the Child Guidance Clinic. Additionally, once a week an Adolescent Medical Specialist meets with every new admission and conducts an assessment, completes STD and pregnancy testing as well as sex education.
In the current population, one resident was identified as having disclosed a previous sexual abuse. However she was discharged prior to interviews. Her file and the secondary documentation of Mental Health assessment were provided to me. She was assessed immediately upon admission. Two residents were identified as having perpetrated prior sexual abuses and both were seen by the MH therapist from Child Guidance upon admission. Interviews and documentation demonstrate compliance with the standard. Because all residents are assessed both medically and by a mental health professional as part of Intake, this standard has been exceeded.
There is no corrective action needed.

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.

Documents Reviewed:
PREA Policy
MOU with Riddle Hospital
Interviews:
Nurse
Master's Level Mental Health Caseworker
Ten Staff

There have been no incidents that have required emergency medical services. The Policy requires that any resident who requires emergency services be taken to Riddle Hospital for a Forensic Medical Exam. As part of the response, staff would first protect the resident and then immediately notify medical . Medical staff would assess the situation and determine the extent and nature of services needed based on their professional judgment or staff would call 911. This would be done immediately and would be free of charge to the resident.
This is a coed facility and all residents are offered STD testing and follow up. All female admissions are offered pregnancy testing and information and access to all lawful pregnancy related services. This is conducted by the Adolescent Medical Speicalist. Interviews with the Nurse and the Mental Health Caseworker confirmed the policy.
Although there have been no incidents that have required emergency services, the policy is in place and the medical staff are an integral part of the coordinated response.
This standard has been met. There is no need for corrective action.

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.

Documents Reviewed:
PREA Policy
Interviews:
Nurse
Mental Health Caseworker

There were no incidents in the past twelve months and so there were no residents to interview or secondary documentation.
The two Medical staff who were interviewed both stated that the level of care that the residents receive is probably better than community level of care, because they coordinate the follow up and ensure that residents follow medical instructions. They prepare medical aftercare plans for any resident returning to the community or being discharged to another placement.
All residents are offered STD and pregnancy testing.
Any resident on resident offender will be assessed and offered follow up counseling that will be ongoing within 60 days of learning of such an abuse history, but usually the same day as learning of it.
This standard has been met and there is no need for corrective action.

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.

Documents Reviewed:
PREA Policy
Interviews:
PREA Coordinator
Caseworker who is a Member of the Sexual Incident Review Team

There have been no incidents within the past twelve months that have required an incident review. The policy states that an incident review team will convene within 30 days of the completion of the investigation for any substantiated or founded allegation. The team is comprised of the Facility Diretor, PREA Coordinator, Medical, Mental Health and Caseworker with input from any other staff person involved. This team will look at any LGBTI identification, gang status or affiliation, other group dynamics, staffing, training, policy and will physically examine where it occurred. The PREA Coordinator will prepare the report with any recommendations. The recommendation would be followed or the reason for not doing so would be documented.
This standard has been met. There is no need for corrective action.

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.

Documents Reviewed:
PREA Policy
PREA Annual Report from 2009 through 2016
DOJ 2016 Annual Survey.
Interviews:
Facility Director
PREA Coordinator

The policy is in place that requires the collection of data that is utilized in the Annual Report of Sexual Violence. The data is aggregated and compares data from 2009 through and including 2016. Data is collected using information from reports and any other resources.
The DOJ has requested information and it is provided every year. I was provided with the 2016 completed survey.
This standard has been met. There is no need for corrective action.

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.

Documents Reviewed:
PREA Policy
PREA Annual Report
Delaware County Juvenile Detention website
Interviews:
PREA Coordinator
Facility Director

There are Annual PREA Reports from 2009 through 2016 posted on the website. The PREA Coordinator states that he collects all data and prepares the Annual Report. The report compares data from year to year.
All personal identifiers have been removed and noted.
This standard has been met. No corrective action is needed.

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.

Documents Reviewed:
PREA policy
Annual PREA Report 2009-2016
Delaware County Juvenile Detention website
Interviews:
PREA Coordinator
Facility Director

There is a policy which dictates what data and what reports will be posted publicly and specifies that all personal identifiers will be redacted. The website contains Annual PREA Reports from 2009-2016. It contains the initial PREA Audit from 2015. The policy states that all records will be retained for ten years. The data is kept securely by the PREA Coordinator.
This standard has been met. There is no need for corrective action.

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 *Maureen G. Raquet* September 23, 2017

Auditor Signature Date