PREA AUDIT REPORT ☐ INTERIM ☒ FINAL
JUVENILE FACILITIES

Date of report: July 2, 2017

Auditor Information			
Auditor name: Shirley L. Turner			
Address:			
Email: shirleyturner3199@comcast.net			
Telephone number: 678-895-2829			
Date of facility visit: June 12, 2017			
Facility Information			
Facility name: Lucas County Youth Treatment Center			
Facility physical address: 225 11th Street, Toledo, OH 43604			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 419-213-6161			
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: Tara L. Hobbs			
Number of staff assigned to the facility in the last 12 months: 41			
Designed facility capacity: 44			
Current population of facility: 17			
Facility security levels/inmate custody levels: Medium			
Age range of the population: 14-18			
Name of PREA Compliance Manager: Patti A. Redfern		**Title:** Assistant Administrator	
Email address: Predfern@co.lucas.oh.us		**Telephone number:** 419-213-6165	
Agency Information			
Name of agency: Lucas County Court of Common Pleas, Juvenile Division			
Governing authority or parent agency: *(if applicable)* Lucas County Court of Common Pleas, Juvenile Division			
Physical address: 1801Spielbusch Avenue, Toledo, OH 43604			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 419-213-6778			
Agency Chief Executive Officer			
Name: Denise Navarre Cubbon		**Title:** Administrative Judge	
Email address: dcubbo@co.lucas.oh.us		**Telephone number:** 419-213-6778	
Agency-Wide PREA Coordinator			
Name: Tara L. Hobbs		**Title:** Administrator	
Email address: thobbs@co.lucas.oh.us		**Telephone number:** 419-213-6163	

AUDIT FINDINGS

NARRATIVE

The Lucas County Youth Treatment Center, located in Toledo, Ohio, provides residential treatment services to youth who otherwise may be committed to the State of Ohio and placed in an Ohio Department of Youth Services correctional facility. The facility is a 44-bed secure residential treatment facility that houses male and female juvenile offenders who have committed felony offenses. The facility's system-based treatment planning focuces on several areas including:
*Correcting criminal thinking;
*Promoting pro-social attitudes, values and belief;
*Addressing family patterns and relationships;
*Developing socially appropriate ways to manage emotions and conflicts;
*Supporting academic and vocational achievement; and,
*Participation in restorative justice activities.

The facility is operated by the Lucas County Court of Common Pleas, Juvenile Division. The age range of the population is 14-18 and the average length of stay is seven months. The Lucas County Treatment Center is a medium level security facility and the residents's custody level is medium. The mission statement for the facility is "to rehabilitate juvenile offenders and their families by developing pro-social attitudes, values, beliefs and skills to increase community safety, reduce victimization, and support youth reintegration with opportunities to demonstrate accountability and responsibility." The programs and services offered include but are not limited to: individualized treatment plans; cognitive behavioral therapy; individual and family counseling; gender specific programming; academic instruction; community service; and re-entry services.

A Registered Nurse conducts nursing assessments and coordinates medical services. A Nurse Practitioner visits the facility one day per week and the physician is on-call to the facility 24/7 and visits the facility as needed. Forensic medical examinations are not conducted at the facility and will be conducted at Mercy's St. Vincent Medical Center in Toledo by qualified medical personnel. Mental health and counseling services are provided by the Lead Therapist and four Therapists. A resident's mental health needs are identified during the assessment process and the needs are addressed through treatment planning; individual and family education; medication management; collaboration with private and community mental health professionals; and discharge planning. A psychologist and psychiatrist provide services to the facility along with the court psychologist, as needed. Academic instruction is provided to all residents through the Toledo Public Schools. Educational goals are individualized and classroom instruction is based on the achievement level of the residents.

Direct care staff members are responsible for the general supervision of the residents and assist in creating and maintaining a positive culture among the residents. The comprehensive tour of the facility revealed that staff members provide direct supervision and there were positive interactions between the staff and residents and among the residents. Recreation services are provided that include the use of space for both outdoor and indoor activities. The facility has a weight and work-out room and share the use of a gymnasium with another program on a scheduled basis. There is the space and opportunity for large muscle exercises and an array of activities for the residents.

Community service projects for the residents include but are not limited to activities with the Toledo Humane Society, Cherry Street Mission, and the Rise and Shine Academy. Families are encouraged to visit the facility through generous visitation opportunities offered by the facility that has included regularly scheduled visitation days during each week; monthly birthday celebrations; Family Chili Day; and Ice Cream Social. The residents interviewed were aware of the visitation days and the phone call days. The facility identifies quality of life activities that occur at the facility and the list includes but is not limited to: monthly Bible study; Cinco De Mayo celebrations; facility Chess Club; community speakers; and Black History Celebrations. Community outings for residents has included: Toledo Museum of Art; Charles H. Wright Museum of African American History; Toledo Zoo; and Toledo-Lucas County Library for the author series events. Special Events are scheduled throughout the year.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Lucas County Youth Treatment Center is located in a four-story building in downtown Toledo. The building primarily consists of four single cell housing units, one for females and three for males; five classrooms; library; weight room area; gymnasium; outside recreation area; medical clinic; offices; large conference room; small meeting room; multi-purpose room and storage areas. The central control is on the first floor, at the entrance of the building. Visitors are received and required to sign in and out in the lobby at central control. The security camera system is located in central control where areas of the facility, inside and outside, are constantly viewed and monitored. The gymnasium and the outside basketball court are shared with a community facility for adults, located next door to the Youth Treatment Center. The use of the gymnasium and the basketball court is scheduled so that each program uses them separately. Direct supervision is provided by staff and all resident movement is monitored by staff and electronically through the camera system. There are no multiple occupancy cell housing units and no open bay/dormitory housing units. A room has been designated the “Chill Space” that is used for de-escalation purposes and to teach coping skills to residents.

Each housing unit has a dayroom area which provides space that allows for residents to congregate in a comfortable and orderly manner. There are showers on each housing unit and the residents shower separately. Doors have been added to the bathroom stalls since the last audit to replace the shower curtains at each stall. The addition of the doors improves the reasonable amount of privacy for the residents. The procedures for using the bathroom and showers are posted in each bathroom. Signs have been added at the entrance of the housing unit, reminding the opposite gender staff to announce themselves when entering an opposite gender housing unit. The posted signs are in addition to the buzzer that was already installed and being used during the facility’s PREA audit in 2014. The lighting was adequate throughout the facility and the appearance of the facility remains clean and orderly.

Enhancements have been made since the last PREA audit that support direct supervision by staff such as additional cameras and additional signs that indicate the restriction of resident movement in certain areas of the facility. Posted signs indicate where residents are allowed only with staff and areas where residents are not allowed. Cameras have been placed in all of the electrical closets although residents are prohibited from enterining them and have also been added to each section of the stairway. During the comprehensive tour of the facility, posters and signs were observed in various areas regarding reporting allegations of sexual abuse or sexual harassment and for contacting the victim advocacy agency. The number of staff currently employed at the facility who may have contact with residents is 39 and the number of staff hired during the past 12 months who may have contact with residents is five. The facility identifies 17 volunteers and contractors who are currently authorized to enter the facility that may have contact with residents.

SUMMARY OF AUDIT FINDINGS

At least six weeks prior to the site visit, the signs announcing the audit site visit and this Auditor's contact information were posted and pictures were sent to this Auditor via email and the areas of the postings were identified. During the comprehensive facility tour, the printed notifications of the PREA site visit were observed to be posted in various areas of the facility, accessible to residents, staff and visitors. The PREA Pre-Audit Questionnaire, policies, and supporting documentation were uploaded to a flash drive and mailed to this Auditor. After a review of the information provided, a written review was sent to the Ohio Department of Youth Services (ODYS) PREA Administrator and the facility to seek clarification of information and request additional documentation. There was communication with the ODYS PREA Administrator and the facility staff during the document review process, as needed. The additional documentation that was requested was provided and the facility created folders, provided onsite, of all of the related documentation. The folders were easy to review and very well organized.

The site visit was conducted June 12, 2017 and Flora Boyd, certified PREA Auditor, assisted with the audit. An entrance conference was conducted and included management staff, other key staff members and the ODYS PREA Administrator. A comprehensive tour was concucted after the entrance conference and included all areas of the facility and outside recreation area. Contact was made by telephone with a representative from the victim advocacy agency, YWCA H.O.P.E. Center, who verified the services of the agency to the facility as stated in the Memorandum of Understanding between the Center and the Lucas County Juvenile Court/Lucas County Youth Treatment Center.

Nine residents were interviewed that included all housing units and seven direct care staff members were interviewed that covered all three shifts. There were 14 specialized staff interviews conducted and included a contractor and volunteer. The interviews with staff members and residents revealed that they are very aware of the zero-tolerance policies of the facility and understand how to report allegations of sexual abuse and sexual harassment. The residents were very articulate in all areas of the interview questions. Staff members were knowledgeable of their duties and responsibilities in preventing, detecting, and responding to all forms of sexual abuse and sexual harassment. An exit conference was held at the conclusion of the the site visit and a summary of the audit findings was provided. The facility Administrator, Assistant Administrator, other members of the facility's management team, and the ODYS PREA Administrator were present during the exit conference.

Number of standards exceeded: 2

Number of standards met: 37

Number of standards not met: 0

Number of standards not applicable: 2

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The primary PREA policies for the facility are XX-6, PREA Compliance and Policy XV-23, The Coordinated Response and Investigations of Allegations of Sexual Assault, Sexual Abuse, and Sexual Harassment. These Policies along with other supporting policies provide the guidelines for zero-tolerance of all forms of sexual abuse and sexual harassment and outlines the approach for preventing, detecting, and responding to such allegations. The primary and supporting policies are aligned with the PREA Standards and each policy is identified by the number(s) of the related Standard(s).

The PREA related policies outline the strategies for addressing the components of the PREA Standards and include the following: prevention and responsive planning; training and education; risk screening; reporting; official response following a resident report; investigations; discipline; medical and mental care; and data collection and review. The PREA Compliance Policy contains definitions of the prohibited behaviors and addresses sanctions to be used when the policies are violated.

The facility Administrator serves as the PREA Coordinator and the Assistant Administrator serves in the role of the PREA Compliance Manager. The Administrator and the Assistant Administrator confirmed their roles through interviews and a review of the PREA Compliance Policy and the facility's organizational chart verified the roles and shows that the Assistant Administrator/PREA Compliance Manager is directly under the supervision of the Administrator/PREA Coordinator. Both were interviewed regarding their roles and both stated that they had the time and the authority required to fulfill their PREA related duties.

The job description of the Administrator contains a reference to the Administrator, among other duties, serving as the PREA Coordinator. Interviews conducted with random staff also confirmed their awareness of the roles of the Administrator and the Assistant Administrator. Both the Administrator and the Assistant Administrator were able to articulate their processes of engaging other staff in the PREA compliance efforts and processes for achieving compliance with the standards.

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.

The standard is not applicable; the facility does not contract with other facilities for the confinement of 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.

The PREA Compliance Policy address staffing, supervision and monitoring. The Policy detatils the considerations for staffing and provides guidance to staff in adhering to the staffing ratios of 1:8 during the waking hours and 1:16 during the sleeping hours. The work schedules and obsevations during the comprehensive facility tour showed the adherence to the staffing ratios and the facility policy. A staffing plan chart, aligned with policies, was developed that shows the required staff assigned to each shift. The staffing plan provides for the staffing ratios to be met and additional staff for days and times when increased staffing is required.

During the interview with the Administrator, there was discussion of how the facility was able to develop previous part-time positions into full-time positions to meet the staffing requirements. She further stated that whenever staffing vacancies occur, each shift is reviewed to ensure that staff membes are deployed to ensure that the ratios are met. The Assistant Administrator/PREA Compliance Manager explained during the interview how the staffing levels and shift assignments are based on many factors that include: security and programming needs; consideration of blind spots in conjuction with the use of cameras and mirrors; number and make-up of the population; requirements of policies, guidelines and PREA Standards; supervisors on duty; activities within the facility; and adherence to initiatives to prevent incidents of sexual abuse.

The PREA Compliance Policy provide that at least once a year a review of the staffing plan occurs. The policy requires that the review considers any adjustments that need to be made in the staffing plan; prevailing staffing patterns; deployment of monitoring technology; or the allocation of resources. The annual staffing plan assessment activities have been captured more succinctly due to a recommendation of the auditor through the completion of a single document, Staffing Plan Assessment form, that provides specific documentation of the review of the staffing plan; monitoring system; and the process for conducting unannounced rounds. The form summarizing the review is signed and dated by both the Administrator and the Assistant Administrator. During the comprehensive tour of the facility, observations were made of additional cameras and mirrors that address blind spots identified through assessments and reviews conducted by the Administrator, Assistant Administrator, other facility staff, and the ODYS PREA Administrator.

The interview conducted with theAdministrator and a review of the PREA Compliance Policy verified that the facility will continue to comply with the current staffing plan except during limited and discrete exigent circumstances and the deviations will be documented. According to the Administrator, on-call staff members may work temporarily during an emergency situation. The facility reports that the average daily number of residents during the past year is 22 and the average daily number of residents on which the current staffing plan was predicated is 22. The facility reports that in the past 12 months there was one deviation from the facility's staffing plan regarding gender mix of staff coverage for one hour. The documentation was reviewed on the Shift Coverage Plan form. The required staffing ratio number of staff to youths was met. Twelve-hour shifts are utilized, 6:30am – 6:30pm and 6:30pm – 6:30am.

A review of documented unannounced rounds and the PREA Compliance Policy support that unannounced rounds are conducted by leadership, management and supervisory staffs on a regular basis and on both shifts. The unannounced rounds are conducted throughout the facility to identify and deter sexual abuse and sexual harassment. A review of camera footage and an interview with a Supervisor/Manager confirmed that unannounced rounds occur. Each staff member that conducts an unannounced round completes the form, Unannounced PREA Inspection Checklist, which contains the various areas of the facility indicating the areas to be checked. It is recommended that an end time be added to the form so that the end time for the visit is also determined from a review of the form. The Policy, which is supported by practice, is that staff does not alert other staff when the rounds are occurring. According to the Policy, staff who alert other staff regarding the unannounced rounds will be subject to disciplinary action unless there is a legitimate reason for the announcement.

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.

Three policies address this standard, Frisk Search/Pat-Down Search; Admissions; and Placement of Residents in Living Units. The Policies provide guidance to staff regarding searches and address the type of searches to be conducted. According to the Frisk Search/Pat-Down Search Policy, cross-gender strip and cross-gender visual body cavity searches are prohibited at the facility. Cross-gender pat-down searches are not permitted, except in exigent circumstances. The interviews with direct care staff members, residents and facility Administrator confirmed that cross-gender pat-down searches are not conducted. While policy exists that addresses exigent circumstances and training is provided, staff related that for a cross-gender pat-down search to occur, there would be no other options available. The Policy provides that any cross-gender pat-down search must have prior approval by the Administrator. The facility reports that no type of cross-gender searches have been conducted at the facility during this audit period. Searches are conducted and are documented by staff, per Policy.

A review of training rosters and training powerpoint presentations and random staff interviews confirmed that staff members have received training in conducting cross-gender pat-down searches and pat-down searches of transgender and intersex residents. The Placement of Residents in Living Units Policy prohibits staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status; this information was also verified through random staff interviews. When the genital status of a resident is unknown, learning this information would be part of a broader medical examination conducted by a medical practitioner in private.

The Admissions Policy provides guidance to staff regarding procedures that ensure that residents are able to shower, change clothes and perform bodily functions without being viewed by staff of the opposite gender. Random staff and resident interviews, observations of posted shower and bathroom procedures confirmed the practices for residents being provided reasonable privacy. During this audit period, doors have been installed outside of the commodes, as well as the shower stalls.

The Placement of Residents in Living Units Policy inform staff that they must announce themselves and ring the bell posted at the unit doors when they are entering the areas where residents of the opposite gender may be showering, changing clothes or performing bodily functions. Signs have also been placed at the entrance of each housing unit, reminding opposite gender staff to announce themselves upon entering the unit. According to staff and resident interviews, the opposite gender staff announce their presence verbally and ring the door bell when entering their living areas. The practice of opposite gender anouncements and ringing the door bell was observed during the comprehensive tour of the facility.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The Orientation/Issuance of Resident Handbook addresses securing support services for disabled residents to receive PREA education. The Lucas County Juvenile Court is the contact for the provision of interpreters and other support services, including services for the hearing impaired, intellectual disabilities, and based on the need of the resident. The Primary Lead Therapist is responsible for securing the services needed and the Administrator approves the use of the identified services and ensures payment. The PREA education pamphlet is also available in Spanish.

The Policy requires that residents with disabilities and who are limited English proficient be provided with the support services that would enable the identified residents to participate in or benefit from all aspects of the PREA education sessions with the goal of preventing, detecting, and responding to sexual abuse and sexual harassment. Identified staff members are also available to assist residents as needed in understanding the PREA education information. The facility reports that during the past 12 months there has not been a need for interpreters.

The Orientation/Issuance of Resident Handbook Policy provide that the facility does not rely on resident interpreters, resident readers or any type of resident assistants, except in limited circumstances where an extended delay in obtaining an interpreter could compromise a resident's safety; performance of first responder duties; or investigation of allegations of sexual abuse or sexual harassment. The random staff interviews indicate that residents have not been used as interpreters, readers or in any way to provide interpretive services during this audit period. The resident handbook contains information regarding reporting allegations of sexual abuse and sexual harassment. Reporting information is also posted on the living units and in the medical clinic.

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.

The following policies address hiring and promotion processes and decisions: Pre-Employment; Hiring and Promotion; Contract Personnel, Juvenile Justice System and Community Agencies; Code of Ethics for Staff Members; and Policy 6.6 of the Court of Commom Pleas, Lucas County Ohio, Juvenile Division. The collective Policies and interview with the Human Resources & Employee Benefits Director provided details regarding the hiring process, completion of background checks, and the grounds for termination. The Policies are aligned with the requirements of the standard and provide that background checks occur and that child abuse registries are checked prior to employment and every five years thereafter. A review of documentation and the interview with the Human Resources & Employee Benefits Director confirmed the practices.

The employment application seeks information from applicants regarding previously related misconduct and according to the Human Resources & Employee Benefits Director, it is also addressed during the interview. The Pre-Employment; Hiring and Promotion; and Contract Personnel, Juvenile Justice System and Community Agencies Policies include prohibiting hiring or promoting anyone who may have contact with residents and prohibit enlisting the services of any contractor who may have contact with residents who has engaged in previous misconduct. The Pre-Employment and Hiring and Promotion Policies and the interview confirmed that the facility considers any incidents of sexual abuse or sexual harassment in determining whether to hire an employee or contractor or whether to promote an employee.

The facility reports that in the past 12 months, there have been five new hires who may have contact with residents that had criminal background checks conducted. During the past 12 months there have been no contracts for services where criminal background record checks were required. The personnel office provides documentation acknowledging the completion of the required background checks. The Employee Handbook provides that staff has a continuing duty to report related misconduct and policies provide that omissions of such conduct or providing false information will be grounds for termination. The interview with the Human Resources & Employee Benefits Director and a review of documentation were aligned with the facility policies.

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)

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The camera system works in conjunction with direct staff supervision and mirrors that are strategically placed to keep residents safe from sexual abuse. There have been upgrades to the camera system which include the installation of additional cameras in identified blind spots such as the weight room, stairwell sections, mechanical room, and other areas throughout the facility. Additional cameras have also be placed in areas to inhance the viewing of residents while they are engaged in various activities. The monitoring system has also been updated to include volumn and clearer visual observation capacity. There has been no expansion or modification to the building since the last PREA audit in 2014.

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)

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Evidence protocol and forensic medical examinations are addressed in three documents: The Coordinated Response and Investigations of Allegations of Sexual Assault, Sexual Abuse and Sexual Harassment Policy; Memorandum of Understanding (MOU) with the Toledo Police Department; and the Sexual Abuse/Assault, Handling of Safety Policy of Mercy St. Vincent Medical Center. Members of the facility's management team conduct administrative investigations and have received related training conducted by the Ohio Department of Youth Services and through the National Institute of Corrections. The Toledo Police Department is responsible for conducting investigations that are criminal in nature and the roles of the Police Department and the facility are outlined in the MOU.

A review of training documentation and the interview with a facility investigator demonstrates that the identified facility investigators have received training on conducting PREA related administrative investigations. Facility policy contains the guidelines outlining the requirements for PREA related investigations. The interview with the Administrator, Assistant Administrator and a review of the MOU provide for communication between the facility and the Toledo Police Department. The interviews confirmed that the point of contact for the Police Department regarding and investigation would be the facility Administrator.

The Coordinated Response and Investigations of Allegations of Sexual Assault, Sexual Abuse and Sexual Harassment Policy and the MOU address the extent the facility is responsible for investigating and cooperating with an investigation conducted by the Toledo Police Department and that the PREA standards will be followed. The Policy ensures that the protocol for administrative investigations is appropriate for youth. The facility maintains evidence bags and safety tape in the control booth. The policies of the facility and Mercy St. Vincent Medical Center outlines the forensic services that would be provided to an alleged victim, focusing on the forensic examination which would be conducted by a Sexual Assault Nurse Examiner (SANE). The Coordinated Response and Investigations of Allegations of Sexual Assault, Sexual Abuse and Sexual Harassment Policy provide that the forensic medical examination and related treatment that will be provided will be at no cost to the victim. The policy, MOU and staff interviews support that practices will be implemented that maximizes the potential for preserving usable physical evidence for administrative proceedings and criminal prosecutions.

A MOU also exists between the Lucas County Juvenile Court and the YWCA H.O.P.E. Center to provide victim advocacy services to residents. In addition to other support services the agency also provides a 24-hour crisis line. The Lucas County Youth Treatment Center also makes trained and qualified staff available to accompany and support a victim per the victim's request. A review of the identified staffs' credentials, including licenses and training, document the staffs' appropriateness to serve in the role of an advocate. Specific information regarding the roles of advocates and and advocacy services is posted by the phone which is dedicated for the use of residents reporting

sexual abuse or sexual harassment or who may be requesting advocacy services. There has been one allegation during this audit period and it resulted in an administrative investigation. There were no allegations referred for criminal investigations and no forensic examinations have been conducted.

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.

The PREA Compliance Policy and interviews with random staff, Administrator and Assistant Administrator provide that allegations of sexual abuse and sexual harassment will be investigated and sexual abuse allegations will be referred to the Toledo Police Department. Administrative investigations are conducted by trained facility investigators which includes the facility's management team. The MOU with the Lucas County Police Department confirms that the allegations that are criminal in nature will be investigated by the Police Department.

During the past 12 months there was one allegation of sexual harassment that received an administrative investigation and there were no allegations referred for a criminal investigation. The Policy directs staff to report all allegations of sexual harassment or sexual abuse and to document the reports. The implementation of the requirements of the Policy was verified through staff interviews and a review of documentation. The agency's website contains the steps to take and contact information for reporting allegations of sexual abuse and reporting information is also posted in various areas of the facility, including the lobby.

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.

The Staff Training Policy addresses PREA related training for staff. In addition to a review of the Policy and training materials, staff interviews and a review of training rosters document that the staff training occurs. All staff interviewed were familiar with the PREA information regarding primary components of preventing, detecting and responding to sexual abuse or sexual harassment. Basic PREA training is provided to staff, as indicated by annual training logs and acknowledgement forms; refresher training is also provided for staff where indicated. The direct care, medical and mental health staffs staffs and an administrative investigator interviewed reported receiving the PREA training as required. The facility houses males and females and the training considers the needs of the population served.

All random staff interviewed verified that the general topics below were included in the training:
*Facility zero-tolerance and PREA related policies;
*Staff responsibilities regarding allegations or incidents of sexual abuse or sexual harassment;
*Resident's right to be free from sexual abuse and sexual harassment;
*The right for staff and residents to be free from retaliation for reporting allegations or cooperating in an investigation;

*Dynamics of sexual abuse and sexual harassment in juvenile facilities;
*Residents and employees rights to be free from retaliation for reporting sexual abuse and sexual harassment;
*How to avoid inappropriate relationships with residents;
*Common reactions of sexual abuse and sexual harassment juvenile victims;
*Communicating effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender non-comforming residents;
*Mandatory reporting; and
*Relevant laws regarding the applicable age of consent.

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.

The Policies that address volunteer and contractor training are: Contract Personnel, Juvenile Justice System, and Community Agencies; Volunteers; and PREA Compliance. A sample of acknowledgement forms were reviewied and this form also provides an outline of the training provided which includes a review of the zeo-tolerance regarding sexual abuse and sexual harassment. The acknowledgement form documents that volunteers and contractors understand the facility's zero-tolerance of sexual abuse and sexual harassment. The interviews with a volunteer and a contractor confirmed that they received the PREA training including their role in reporting allegations of sexual abuse or sexual harassment.

The contractors and volunteers are informed of their responsibilities regarding sexual abuse prevention, detection, and response to a PREA allegation and based on the services they provide as determined from the written training presentation, acknowledgement forms, and interviews. The volunteer and contractor were able to articulate the contents of the training. The facility reports that the number of volunteers and contractors who have contact with residents and who have received the PREA training is 17.

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.

The Admissions Policy provides that all residents admitted to the facility receive PREA education. The sessions include information about what PREA entails, how to report allegations of sexual abuse and sexual harassment; the right to be free from retaliation for reporting; safety tips; and what may happen if a resident is sexually assaulted, including information about advocacy services. The Policy provides that residents receive initial PREA education within 24 hours of admission to the facility, during the intake process and that comprehensive education is provided within 10 days of admission. A video is also used during the comprehensive review and education sessions are provided as indicated according to Policy. All residents interviewed were very responsive to the questions and reported that weekly

interactive PREA sessions are conducted by one of the Managers.

The Manager who provides a weekly review of the PREA information and safety inquiries as indicated in the resident interviews confirmed the weekly presentations. All of the residents interviewed were very knowledgeable of the PREA related information which is obviously presented in an age appropriate manner. Interviews with the Lead Therapist and Manager also validated the comprehensive training provided to the residents. The residents sign acknowledgement documents confirming receipt of the PREA ecucation. A PREA handbook provides information to residents on how to report allegations of sexual harassment and sexual abuse and condenses the PREA education information provided by staff; each resident also receives a PREA Information Booklet.

Information regarding victim advocacy support services is posted in the living units at the phones dedicated for residents to report sexual abuse or request advocacy services. The residents were also very articulate in their responses to the role of and the services available through a victim advocate. The facility has the capability of providing the PREA education in formats accessible to all residents including those who may be limited English proficient; deaf; visually impaired, or otherwise disabled, and to residents who have limited reading skills. Interpretive and translation services are available through the Lucas County Juvenile Court and through facility staff as needed. All random staff interviewed confirmed that residents are not used as translators or readers for other residents. PREA information is posted in various areas of the facility, including the living units and the lobby; visible to residents, staff and visitors. The PREA Information Booklet is available in different languages.

The facility reports that 38 residents, admitted in the last 12 months, received comprehensive age-appropriate PREA education including the right to be free from sexual abuse and sexual harassment; the right to be free from retaliation for reporting such incidents; and facility policies and procedures for responding to such incidents. According to the Admissions Policy, residents must receive PREA education within 24 hours of admission; however, eight of the nine residents interviewed stated that they received it on the first day of arrival and one reported being involved in PREA education the next day of his arrival.

The Lead Therapist who performs the intake duties stated that she meets with each youth while they are in detention, prior to their placement in the program, and during the admission process once the youth arrives at this facility. She stated that the PREA education sessions include reviewing the PREA brochure and the viewing of a video. All of the residents interviewed were also very knowledgeable of the various ways that they and others can report sexual abuse or sexual harassment. The efforts of the Lead Therapist and the interactive refresher sessions presented by the Manager result in a very informed resident.

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.

Members of the administrative team have been identified as investigators responsible for conducting administrative investigations which is addressed in the Staff Training Policy. Training documentation and the interview with one of the facility investigators confirmed receipt of training and that the training is applied to situations of allegations that do not involve potentially criminal behavior. The investigations that may be criminal in nature are conducted by the Toledo Police Department as described in the MOU between the juvenile court/facility and as confirmed in interviews with direct care staff, Administrator and Assistant Administrator.

The facility investigators received training through the Ohio Department of Youth Services entitled, Crime Scene Preservation & Administrative Investigations. Training was also received through the National Institute of Corrections with the online course, PREA: Investigating Sexual Abuse in a Confinement Setting. The combined training included topics covering techniques for interviewing juvenile sexual abuse victims; proper use of Miranda and Garrity warnings; sexual abuse evidence collection in confinement settings; and the criteria required to substantiate a case. The Staff Training Policy also contains the topics that must be included in the training for conducting administrative investigations.

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.

The Medical Personnel and Mental Health Services Policies address this standard. The mental health and medical staffs receive the general PREA training and also completed the online course by the National Commission on Correctional Health Care which was confimed through the review of training records, including certificates, and interviews with mental health and medical staffs. The Ohio Department of Youth Services has also provided training for mental health staff regarding victim support. The training sources have provided training in areas that include how to detect and assess signs of sexual abuse; responding effectively to victims of sexual abuse and sexual harassment; and reporting sexual abuse and sexual harassment. Forensic medical examinations are not conducted at the facility; they will be conducted at the local hospital.

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The Assessment and New Admissions Policies require that the screening for risk of sexual abuse victimization or sexual abusiveness toward other residents be conducted by mental health staff on each resident admitted to the facility within 24 hours of the resident's arrival. A primary screening instrument is used to assess risk of sexual victimization and abusiveness. A Therapist was interviewed and documentation was reviewed that support the completion of the vulnerability screening process to assess and obtain information that will assist staff in reducing the risk of sexual abuse by or upon a resident.

The interview with the Therapist revealed that much of the information in determining the risk for victimization or abusiveness is obtained through interviewing the youth while he/she is still in detention pending placement in this facility. The Ethics, Professionalism and Standards of Conduct Policy along with the facility's confidentiality policy and the interview with the Administrator addressed the management of sensitive information and the expectation of confidentiality by all staff. Additional information to complete the risk screening instrument and that assists in determining risk levels is through a review of court records, school records, probation file, communication with the resident's Probation Officer, and other pertinent records as supported by policy.

Reassessments are conducted approximately 90 days after admission to the facility and when new information is received based on policy and the interview with the Therapist. Seven of nine residents interviewed indicated that reassessments may be conducted informally in meetings with their Therapists and they are asked about their safety concerns during the PREA education refresher sessions conducted by the Manager. A review of documentation and interviews with the Therapist and residents verified that the vulnerability assessments are conducted as required. The facility reports that the number of youth admitted to the facility within the past 12 months who were screened during the admission process for risk of sexual victimization and the risk of sexually abusing other residents is 38.

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.

The following Policies address this standard: Placement of Residents in Living Units; Behavior Management System; and Shower and Bath Daily. These policies provide that the information obtained from the risk screening is used in considering room assignment; education assignment; and other program assignments in efforts to keep all residents safe. A review of documentation and interviews with the Therapist and Administrator confirmed that the information from the risk screening instrument assists staff in determining housing and program assignments.

The Placement of Residents in Living Units Policy provides that a resident would only be placed in isolation as a last resort for protection and it would only be until other arrangements could be made to keep the resident safe. The Policy also requires that residents receive services which include education, medical and mental health. Interviews with the Nurse, Lead Therapist and Administrator support that the program services would be provided. A review of Observation Sheet forms revealed that the required services are provided to residents when they were in room restriction which were unrelated to PREA. During the last 12 months no residents were placed in isolation because of risk of sexual victimization. Random staff interviews indicated that protective measures would be taken immediately and responses included separating residents; development of a safety plan; provision of close staff supervision; increased monitoring; notification of Shift Leader; and document the situation.

The Placement of Residents in Living Units Policy prohibits placing lesbian, gay, bisexual, transgender, or intersex residents in separate housing based solely on such identification or status and the interviews with residents and staff were aligned with the Policy. The interview with the Therapist and the Policy support that program assignments regarding transgender or intersex residents, including program and housing assignments, would be made on a case-by-case basis. The Policy provides that it is prohibited to consider lesbian, gay, bisexual, transgender or intersex identification or status as an indicator of the likelihood of those residents being sexually abusive.

A review of a sample of risk screening instruments; staff's description of the intake process; and interviews with residents, Lead Therapist and a Therapist confirmed that staff consider each residents' concern for their own safety while they are in the facility. According to the Placementof Residents in Living Units Policy, transgender or intersex residents will be reassessed at least twice a year and must be given the opportunity to shower separately. The Therapist inteview confirmed that she was knowledgeable of the contents of the Policy.

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.

The Resident Reporting of Sexual Abuse Policy provides that internal methods are put in place for a resident to report allegations of sexual abuse; sexual harassment; retaliation for reporting; and staff neglect or other violation that may have led to abuse. A Memorandum of Understanding exists with the YWCA H.O.P.E. Center for victim advocacy services. A rape crisis hotline is provided by the H.O.P.E. Center where the residents may contact the Center directly through an unimped process. The phone number is posted by the phones dedicated for resident reporting and without staff assistance. A phone is placed on each living unit and at the third and fourth floor. Residents may also use the phone in the medical clinic to access the rape crisis hotline. The information regarding the role of an advocacate is posted by the telephones. The information provided is easy for the resident to read and it lists the things an advocate can and cannot do.

During the comprehensive tour, the dedicated phone on a unit was tested and it was in working order. An emergency grievance to report sexual abuse and sexual harassment may be completed and placed in a locked grievance box, accessible to all residents. The posted grievances boxes, grievance forms and suggestion forms were observed posted. Residents have access to writing utensils to complete grievance forms and other complaints in writing. Other written methods that may be used by residents, if he/she chooses, is to complete a Resident Problem-Solving Form or a Suggestion Form. The Resident Problem-Solving Form provides for the elaboration of a problem and what the resident has done or plan to do regarding the problem. A completed Resident Problem-Solving Form is responded to in writing by the Primary Therapist; supervisor; senior supervisor; teacher; or Administrator.

The information about reporting allegations of sexual abuse and sexual harassment is printed in the resident handbook and PREA brochure which is reviewed with and provided to the residents. Reporting information is also posted in various places within the facility, accessible to all residents. Staff members are required to immediately document verbal reports of allegations of sexual abuse and sexual harassment as supported by the interviews conducted with the direct care staff members. The Policy also provides that staff will accept reports that are made anonymously and reports from third-parties, and this was confirmed through staff and resident interviews. The residents interviewed stated that they had access to someone who does not work at the facility that they can report to about sexual abuse or sexual harassment that happened to them or someone else.

Staff collectively responded that they could privately report sexual abuse and sexual harassment of residents through the use of the Lucas County website. In addition to the website, some staff reported that they could talk to administrative staff and/or their supervisor.
All residents and staff revealed through interviews that they are aware of the various ways a resident can report sexual abuse and sexual harassment: verbally, in writing, anonymously, and through a third-party. The quality of the resident PREA education was very obvious through their interviews. Staff members are informed of the residents' methods of reporting through the PREA training they receive. The facility reports that youth are not detained in the facility for civil immigration purposes.

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.

The Grievance, Problem-Solving and Suggestions Policy provides that an administrative process is used in dealing with grievances. Details are contained in the Policy that outlines the residents' grievance process; any third-party assistance to the resident; and appealing the initial decision in response to the grievance. The Policy provides that there is no time limit for filing the grievance and identifies the timelines contained in the grievance process. Emergency grievances are responded to within the hour; no later than 48 hours based on the information within the grievance. Residents are not required to use an informal process or give the grievance to any staff member regarding allegations of sexual abuse. The grievance form is easy to follow and clearly distinquishes emergency grievances allexxging allegations of risk for sexual abuse or allegations that sexual abuse has occurred. The residents have access to grievance forms, writing materials, and locked grievance boxes for depositing the completed grievance form, as determined through observations during the comprehensive tour and interviews with residents and staff.

It is the responsibility of the Assistant Administrator or designee to check the grievance boxes Monday through Friday and a designated Control Booth Operatior checks the boxes on weekends and holidays allowing for the emergency grievances to be responded to within the required timeframes of the policy and PREA standards and that administrative staff may be notified immediately. The Grievance, Problem-

Solving and Suggestions Policy and the information to residents provide that a resident may be terminated from the program and/or criminal charges may be filed for filing a grievance related to alleged sexual abuse only when it has been determined that the resident filed the grievance in bad faith.

There were no grievances submitted alleging sexual abuse or alleging substantial risk of imminent sexual abuse during the past 12 months. All of the residents and direct care staffs interviewed were aware of the grievance process as a method for residents to report allegations of sexual abuse or sexual harassment. The residents and staff are also aware that they are not required to use an informal grievance process or otherwise attempt to resolve a PREA related issue with staff. Residents and staff members are aware that a third-party may make a complaint regarding sexual abuse or sexual harassment.

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.

The Resident Reporting of Sexual Abuse Policy addresses the residents' access to outside confidential support services. The Lucas County Juvenile Court, which includes the Youth Treatment Center, has a Memorandum of Understanding (MOU) with the YWCA H.O.P.E. Center that details the victim advocacy services that will be provided to a resident upon request. The contact information is posted and also provided to the residents during PREA education sessions and in the PREA Information Booklet. The MOU lists the responsibilities of the H.O.P.E. Center and include: access to crisis hotline services; emotional support; intervention services; referrals for resources; and posters with contact information. Victim advocates from the YWCA H.O.P.E. Center will also accompany residents and support the victim through the forensic examination process and through investigatory interviews at the hospital.

The PREA Information Booklet includes the services that will be provided by the H.O.P.E. Center and includes a list of the advocacy services including information regarding confidentiality and how to access the services. The information in the Policy, MOU, PREA Information Booklet is aligned with the PREA standard and was supported by all of the resident interviews. The staff interviews also revealed their knowledge of and the role of the YWCA H.O.P.E. Center. A telephone interview with the Director of the H.O.P.E. Center confirmed the contents of the MOU and the services available to the residents upon request and described a cooperative working relationship with the facility. During the comprehensive tour of the facility, the dedicated phones were checked and were in working order and the test call to the advocacy agency was answered directly by H.O.P.E. Center staff.

The interviews with the Administrator/PREA Coordinator, review of the MOU and Policy, printed materials and posted information confirmed that the residents have access to victim advocacy services. All resident interviews and the interview with the Administrator and Assistant Administrator and observations during the comprehensive tour support that residents are provided confidential access to their attorney or other legal representative and reasonable access to their parents/legal guardian. All residents were aware of how they could communicate with their parents/legal guardian and that attorneys and court workers could visit the facility. Residents also confirmed that they had someone on the outside to report allegations of sexual abuse if they needed to. Residents were aware of all of the visitation and telephone days.

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.

The Resident Reporting of Sexual Abuse contains the information regarding third-party reporting of sexual abuse or sexual harassment. Lucas County Juvenile Court has a link on its website for third-parties to make reports and reports may be made anonymously. Staff may also use the website to make third-party reports and they may also make anonymous reports. During the intake process, families are informed about how they can report allegations of sexual abuse and sexual harassment. Parents may also access a copy of the PREA Information Booklet from the facility's website and from the facility.

Interviews with direct care staffs revealed that they are aware of their obligation to receive and submit reported allegations from others. They also expressed that the ways they may report privately is through the website and tell their supervisor. Staff members are also aware that they are to document all verbal reports. Interviews with residents confirmed their knowledge of what third-party reporting meant. The residents shared the methods within the facility in which residents may make thir-party reports such as the grievance system, talking to staff, and utilizing the abuse reporting hotline.

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.

The Suspected or Alleged Child Abuse or Neglect; Code of Ethics; and PREA Compliance Policies address this standard. All staff members are mandated reporters and must immediately report all allegations of sexual abuse and complete a written follow-up report. The Code of Ethics Policy requires staff to comply with the mandatory reporting laws. The Policies collectively provide guidance to staff in their reporting duties and prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigations, and other security and management decisions. All direct care staff members interviewed provided information that was aligned with the reporting requirements and that the expectation is that reports are documented immediately. The facility staff members are also required by policy to report allegations that were made anonymously or by a third-party.

Based on interviews with the mental health and medical personnel, residents are informed of the staffs' duty to report. Administrative investigations are investigated by the identified facility staff members and allegations that are criminal in nature are investigated by the Toledo Police Department.. The policies and staff interviews reveal that notifications will be made immediately, including to the courts; appropriate child welfare agency; and parents/legal guardians. The interviews with the Administrator and the Assistant Administrator supported the other staff interviews and the aforementioned policies.

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.

The combined Code of Ethics and PREA Compliance Policies require staff to protect the residents through immediately implementing protective measures. The summarized interviews of the direct care staff and the facility Administrator revealed that protective measures include: separate the the victim from the perpetrator; report the situation to supervisor and management staff; document the situation; obtain statements from the residents involved; and change housing assignments. The Administrator stated that her expectations are that actions to protect a resident would be implemented immediately and the Residential Specialists/direct care staffs verbally confirmed that proactive measures would be implemented immediately. The facility reports that during the past 12 months, no residents were identified as being subject to substantial risk of imminent sexual abuse.

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.

The Suspected or Alleged Child Abuse or Neglect Policy provides that upon the facility receiving an allegation that a resident was sexually abused while confined in another facility, the Administrator will notify that facility's administrator and will also notify the Lucas County Children Services as soon as possible but no later than 72 hours after receipt of the allegation and document the notification. The Policy also provides that the Youth Treatment Center Administrator requests documentation from the facility where the alleged incident occurred confirming that the allegation has been referred for investigation.

The facility reports that there were no allegations received of a resident being sexually abused while confined in another facility during this audit period. The Suspected or Alleged Child Abuse or Neglect Policy also requires that all allegations of sexual abuse be made to the Lucas County Juvenile Court and the Bureau of Community Corrections at the Ohio Department of Youth Services. The Policy, interview with the Administrator and a review of the applicable form support that allegations of sexual abuse or sexual harassment from a resident regarding his/her stay in another facility will be reported and investigated as required. There have been no such allegations made by a resident.

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.

The Coordinated Response and Investigations of Allegations of Sexual Assault, Sexual Abuse, and Sexual Harassment Policy requires that

any staff acting as a first responder must separate the alleged victim from the alleged abuser; call for help; and take the appropriate steps for the preservation and collection of any evidence. The Policy directs the first responder to request that the alleged victim does not wash; brush their teeth; change clothes; wash or do anything that may destroy evidence.

Interviews with staff members who would serve as first responders and a non-security staff revealed that they are aware of their duties. The Policy instructs non-security staff who may act as a first responder to request that physical evidence be preserved and to contact direct care staff for assistance. During this audit period there has not been a criminal investigation regarding sexual abuse conducted by the Toledo Police Department. One administrative investigation was conducted by a facility investigator.

Standard 115.365 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

The Coordinated Response and Investigations of Allegations of Sexual Assault, Sexual Abuse, and Sexual Harassment Policy provides guidance to staff regarding the actions to take when there is an alleged incident of sexual abuse and requires a written facility plan. A review of the written plan shows that it outlines, in a charted format, the role of individuals and the steps to be taken in response to an incident of sexual abuse.

The coordinated response plan is a procedural diagram that identifies the staff positions and their roles, required for an effective facility response, such as the Residential Specialist (direct care); Supervisors/Managers; Administrator/PREA Coordinator; Assistant Administrator/PREA Compliance Manager; medical practitioner; and mental health staff. Staff members are aware of their duties in response to an incident of sexual abuse as determined by a review of the Policy, training records, and coordinated reponse plan, and the interviews with staff.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

This standard is not applicable. The facility does not maintain any collective bargaining agreements.

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.

The Suspected or Alleged Child Abuse or Neglect Policy provides that no resident or employee who reports an allegation and/or cooperates with an investigation will suffer retaliation from other residents or other employees. According to the Policy, the Administrator/designee will assign a Manager to monitor for retaliation. The Administrator stated that the Manager assigned to the resident's unit would be responsible for the retaliation monitoring. The Policy identifies protection measures that may be utilized to monitor for retaliation when a resident or staff member reports sexual abuse or sexual harassment or if they cooperate with an investigation.

The protective measures are stated in the Policy as follows:
a. Regularly scheduled meetings to assess the resident's or staff's interactions with other staff members and residents;
b. Changing resident living unit assignments for resident victims or abusers;
c. Periodically checking status of resident;
d. Removing alleged staff or resident abusers from contact with victims;
e. Providing emotional support services for residents through the YWCA H.O.P.E. Center; and
f. Referring concerned staff members to Employee Assistance Program.
The Manager/supervisor interviewed regarding retaliation supported the requirements in the policy, as well as this Auditor's review of Retaliation Monitoring Checklists.

The Policy and the interviews document that items that would be monitored to assess retaliation include: resident disciplinary reports; requests to change rooms or living units; program changes; negative performance reviews; reassignments of staff; program changes; or negative performance reviews. There have been no allegations of sexual abuse during this audit period; however, a retaliation monitoring form was used to track retaliation activities regarding allegations of sexual harassment which resulted in an administrative investigation by a facility investigator. Additionally, the Policy provides that the retaliation monitoring occurs for at least 90 days. The interview with a Manager, responsible for retaliation monitoring, stated that the monitoring period could be longer and ongoing until the resident is released where indicated.

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.

The Placement of Residents in Living Units Policy addresses this standard and provides that residents who may be placed in protective custody are only isolated as a last resort if less restrictive measures are inadequate to protect the resident and only until an alternative placement could be arranged. The Policy also states that while in isolation the resident will not be denied education, daily large muscle exercise and other program services.

Standard 115.342 is referenced specifically in the Placement of Residents in Living Units Policy directing that any use of isolation to protect a resident who has been sexually abused does not prevent them being afforded educational programming or special education services and daily visits from a medical or mental health clinician and other requirements. According to the Policy, if a

resident is placed in protective custody after suffering sexual abuse, a review to determine whether there is a continuing need for the isolation will be conducted every 30 days.

The facility reports that no residents alleged sexual abuse and were placed in isolation in the past 12 months. The interviews with the Administrator, Lead Therapist and the Nurse support that disciplinary isolation is used infrequently and in short duration; and includes the delivery of the required program services, according to Policy. A review of documentation which includes monitoring forms support adherence to the Policy when isolation is used. Additionally, the staff interviews regarding the use of isolation and related documents reviewed support that the required services will be provided if protective custody is used for a resident who was sexually abused.

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.

The Coordinated Response and Investigations of Allegations of Sexual Assault, Sexual Abuse and Sexual Harassment Policy addresses this standard. It provides that administrative investigations are conducted promptly by administrative staff members who have been identified as an investigator and who have received the required training for conducting investigations in a confinement setting. The administrative investigators have received training through the Ohio Department of Youth Services and the National Institute of Corrections.

Allegations that are criminal in nature are conducted by the Toledo Police Department and sustained allegations will be referred for prosecution. Investigations are not terminated solely because the resident recants the allegation as supported by a Manager who conducts investigations; she added that all allegations are taken seriously. The Policy provides and the interview and a review of documentation support that the facility maintains all written reports pertaining to investigations, according to the standard. There have not been any allegations conducted or sustained by the Toledo Police Department and referred for prosecution. According to interviews, the Administrator will maintain contact with the Toledo Police Department in the event of a criminal investigation.

A review of documentation confirmed that written investigative reports are completed by the trained investigators. According to the Manager interviewed, the training topics included: techniques for interviewing juvenile sexual abuse victims; proper use of Miranda and Garrity warnings; sexual abuse evidence collection in confinement settings; and the criteria and evidence required to substantiate a case for administrative or prosecution referral. The Manager could articulate during the interview the length of time to initiate an investigation; first steps in initiating an investigation; investigation process; how to proceed when a staff member accused of sexual abuse and the alleged victim are no longer at the facility; role regarding a criminal investigation; steps to take to preserve evidence; and provided other related information regarding an administrative investigation.

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.

The Coordinated Response and Investigations of Allegations of Sexual Assault, Sexual Abuse, and Sexual Harassment Policy provides directions to staff regarding the administrative investigations and provides the evidentiary standard for administrative investigations. Members of the management team conduct the administrative investigations and allegations that are criminal in nature are referred to the Toledo Police Department. According to the review of documentation, including the Policy, and interviews with the Administrator, Assistant Administrator and a Manager who conducts administrative investigations, the standard of evidence required to substantiate allegations is no higher than a preponderance of the evidence.

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.

The Coordinated Response and Investigations of Allegations of Sexual Assault, Sexual Abuse, and Sexual Harassment Policy provides that the resident be informed when the investigation has been concluded and the outcome of whether it was determined to be substantiated, unsubstantiated or unfounded. The notification regarding the results of administrative and criminal investigations must be done in writing, which is stated in the Policy. A notification form has been created for the purpose of reporting to residents regarding the outcome of administrative sexual abuse investigations.

The Policy, review of the form, and interterviews with the Administrator/PREA Coordinator and the Assistant Administrator/PREA Compliance Manager confirmed that the resident would receive a completed notification form stating the outcome of the investigation. The form includes notification to the resident for allegations of sexual abuse, sexual assault and sexual harassment. The form also contains the definitions for substantiated, unsubstantiated and unfounded.

The Policy provides that following an allegation of sexual abuse committed by staff, the resident will be informed when the staff member is no longer posted in the unit or employed in the facility and of the staff member's indictment or conviction. Following an allegation of sexual abuse committed by another resident, the alleged victim will be informed if the alleged abuser has been indicted, charged, or convicted. The notification form provides this information to the resident. The Administrator and Assistant Administrator revealed that if there should be a criminal investigation conducted by the Toledo Police Department, the Administrator would remain abreast of the investigation through serving as the primary contact person with the Police Department and that a report would be provided to the facility. There were no investigations conducted for allegations of sexual abuse in 2015-2017.

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.

The Code of Ethics for Staff Members Policy indicates that staff members are subject to disciplinary santions up to and including termination for violations of sexual abuse, sexual harassment policies or the Code of Ethics Policy. According to the Policy, terminations for violations of sexual abuse or sexual harassment policies or resignations by staff who would have been terminated if not for their resignation, will be reported to law enforcement, unless the activity was clearly not criminal, and to relevant licensing bodies.

The disciplinary sanctions for violations relating to sexual abuse or sexual harassment, other than engaging in sexual abuse, will be commensurate with the act committed; the staff member's disciplinary history; and the similar history of other staff. During this audit period no staff member was terminated or resigned prior to termination due to substantiated findings of an administrative investigation regarding an allegation of sexual abuse or sexual harassment. The interview with the Administrator supported the Code of Ethics for Staff Members Policy.

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.

The Contract Personnel, Juvenile Justice System, and Community Agency Policy outlines instructions to implement regarding any contractor or volunteer engaging in sexual abuse. The Policy indicates and the Administrator interview supports that when a contractor or volunteer engages in sexual abuse with a resident, contact with the resident will be prohibited and law enforcement will be notified, unless the activity was clearly not criminal, and contact will be made to relevant licensing bodies. The Policy provides that regarding contractors and volunteers, appropriate remedial measures be taken and consideration be given to whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies.

Contractors and volunteers acknowledge receipt of the PREA training. During the past 12 months, there have been no contractors or volunteers who have been reported for a violation of PREA policies. A review of documentation, and interviews conducted with the Administrator, a contractor and a volunteer confirmed that the PREA training occurs. The volunteers and contractors are aware of the zero-tolerance policies and how to report allegations of sexual abuse and sexual harassments of residents.

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.

The Behavior Management System Policy addresses this standard and provide that residents may be subject to disciplinary sanctions only

after formal proceedings regarding resident-on-resident sexual abuse. The Policy supports the premise that residents found in violation of facility rules are subject to sanctions pursuant to the administrative process or following a criminal finding of guilt. The Behavior Management System Policy and the PREA Compliance Policy collectively address the requirements of the standard, including that any sanctions applied will be consequences through the behavior management system, removal from the program, and/or criminal charges filed. The facility provides for treatment services should a resident remain in the program that would include therapy; development of Boundary Plans; and program and room assignments. Interviews with mental health and medical clinicians and the Administrator support that if a resident remains or returns to the facility after resident-on-resident sexual abuse that the resident's mental condition would be considered when determining sanctions and in accordance with the behavior management system, including use of disciplinary isolation.

The Behavior Management System Policy provides that if a resident-on-resident abuse result in the use of isolation, the resident in isolation must be provided daily access to large muscle exercise and educational services, including special education if identified for the resident. A review of the observation sheets for use of isolation in situations unrelated to sexual abuse, demonstrate that the required services to residents will be delivered by staff if a resident is placed in isolation for resident-on-resident sexual abuse. One observation sheet has been designed to document reason for the room restriction; administrative approval; visits/assessments by Therapist and Nurse; and provision of education services. The other observation sheet reviewed, documents the large muscle activity offered; time and duration of activity; whether or not resident refused the activity; and observations of the identified staff member during the large muscle activity.

The behaviors that residents may be disciplined for including PREA related behaviors are addressed in the Behavior Management Policy and the handbook. A review of documentation and Policy support that disciplinary sanctions have been developed to be commensurate with the nature and circumstances of a violation; resident's disciplinary history; similar histories of other residents; and consideration of mental disabilities or mental illness contributing to the behavior. The residents are informed of the disciplinary process and disciplinary actions for unacceptable behaviors including sexual abuse and sexual harassment. They are also informed about removal from the program and that some rule violations may result in legal consequences. Interviews with medical and mental health personnel and a review of related documentation revealed that a resident's participation in treatment services would not be required for him/her to access programming or education.

The facility may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact and a resident who reports an allegation of sexual abuse will not be disciplined or considered to have made a false report if the allegation was made in good faith, according to policy. The agency prohibits all sexual activity between residents and staff interviews and policy document that the facility considers that sexual activity consititutes sexual abuse only if it is determined that the activity was coerced. There was not an incident, during the past 12 months, of administrative findings or findings of guilt regarding resident-on-resident sexual abuse.

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.

The Mental Health Services and Special Needs Health Care Policies address this standard. It is required that when a resident discloses prior victimization or abusiveness during the intake screening process, a follow-up meeting will be provided with a mental health or medical practitioner within 14 days of the intake screening. The facility reports that during the past 12 months there were no disclosures during the intake process of a resident being a previous victim of sexual abuse or having previously perpetrated sexual abuse. According to the Therapist interviewed, the facility obtains information on each resident from various sources includeing Probation Officers, court records, applicable mental health and other records.

All residents are screened during the intake process to measure their level of vulnerability. If prior victimization or abusiveness is learned through the admissions process, a follow-up meeting will be scheculed or the clinician will conduct the follow-up meeting, as supported by the interview with the Lead Therapist. Observatioons of processes and review of records demonstrate that medical and mental health staffs maintain secondary materials that document all encounters and demonstrate that the same would be done regarding disclosures of residents' prior victimization or previously perpetrated sexual abuse. According to policy, no information is to be shared with other staff unless it is

required for security and management decisions regarding sexual abuse history.

The Special Needs Health Care Policy addresses informed consent being obtained for residents over 18 years old prior to the healthcare personnel reporting information disclosed about prior sexual victimization that did not occur in an institutional setting and provide for no conflict with the worker's status as a mandated reporters. The interview with the Lead Therapist confirmed that when a resident may disclose prior victimization or previously perpetrating sexual abuse they will receive a follow-up meeting with medical and mental health staff members during the intake process.

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.

The Coordinated Response and Investigations of Sexual Assault, Sexual Abuse, and Sexual Harassment Policy ensures timely and unimpeded emergency medical and mental health services related to sexual abuse and the services will be provided at no cost to the victim and whether or not the victim names the accuser or cooperates with the investigtion. The interviews with the Nurse and the Lead Therapist confirmed that a victim of sexual abuse would receive immediate and unimpeded access to emergency medical treatment and crisis intervention services. Both the Nurse and the Lead Therapist reported during their interview that the nature and scope of these services would be determined according to their professional judgment.

Policies and procedures and a written coordinated response plan exist for contacting the appropriate staff regarding allegations or incidents of sexual abuse, including contacting medical and mental health staffs if they are not in the facility at the time. The PREA Compliance and Code of Ethics Policies provide information to staff regarding protection of victims of sexual abuse. Staff interviews confirmed their awareness of the Policies and the methods to implement for protecting residents. The staff interviews confirmed and policies supports that timely information would be provided to a victim regarding sexually transmitted infection prophylaxis.

The observations of the interactions and delivery of services by medical and mental health practitioners and record keeping indicate that unimpeded services will be available to a victim of sexual abuse. It was determined from staff interviews, review of policy, and observations that medical and mental health staff will maintain secondary materials regarding medical and mental health encounters and the treatment services. The policies address timeliness, documentation and access to emergency medical and crisis intervention services. It was determined through the interviews with medical and mental health staffs; interviews with other staff and residents; review of the written response plan; and observations that immediate medical treatment and crisis intervention services will be provided to an alleged victim of sexual abuse.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

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

corrective actions taken by the facility.

The Special Needs Health Care and Mental Health Services Policies address this standard and provide for ongoing medical and mental health evaluations and treatment, where appropriate, for sexual abuse victims and abusers. The policies and interviews support ongoing medical and mental health care within the facility and may include referrals by the healthcare practitioners for follow-up services, as needed. The Policies support and interviews with the Nurse, Nurse Practitioner and the Lead Therapist agree that the services currently provided in general and that will be provided regarding an incident of sexual abuse are consistent with the community level of care.

Collectively, the Policies and staff interviews document that resident victims will be offered tests for sexually transmitted infections as medically appropriate; provided timely information about and timely access to emergency contraception; and pregnancy tests where indicated. All treatment services will be provided at no cost to the victim. The Lead Therapist confirmed that a mental health evaluation of all known resident-on-resident abusers will be conducted as required and treatment or placement will be provided as deemed appropriate.

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.

The PREA Compliance Policy address this standard and identifies the management team members as the incident review team. Details regarding the role of the incident review team are provided. According to the Policy, the incident reviews will occur within 30 days of the conclusion of the investigation. There will also be input from shift leaders; investigators; Primary Therapist; medical or mental health practitioners, where applicable. The incident review team will consider the factors in the review process such as the need to change policy or practice; motivation factors that may have contributed to the incident; physical barriers; adequacy of staffing levels; and adequacy of monitoring technology.

The PREA Compliance Policy requires that the Administrator/designee ensures that the recommendations of the incident review team be implemented and that when they are not, the reasons are documented. The interviews with the Administrator, Assistant Administrator, and a Manager who will serve as an incident review team member were aligned with the standard. The staff members were familiar with items that must be considered during the incident review process. During the past 12 months, there have been no criminal investigations of alleged sexual abuse conducted at the facility.

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.

The PREA Compliance Policy addresses this standard and provides that the facility will maintain data for allegations of sexual abuse,

including data gathering necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. A review of reports and the interviews with the facility Administrator/PREA Coordinator, Assistant Administrator/PREA Compliance Manager and the ODYS PREA Administrator support that the review of collected data of significant incidents occur.

The facility has the capacity to collect data for allegations of sexual abuse and sexual harassment through current data gathering efforts and aggregate incident-based data at least annually. The identified data has been collected and reviewed and an annual report has been developed. The agency will provide the related data from the previous calendar year to the United States Department of Justice as requested, as stated in the PREA Compliance Policy.

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.

The PREA Compliance Policy addresses this standard including the review of data for the development of corrective actions and it provides for the posting of an annual report, approved by the Administrator, on the facility's website. Data review occurs and corrective actions are implemented as indicated. A PREA related annual report has been prepared and compares the 2015-2016 data. The facility collects data, including PREA related data such as sexual abuse, sexual harassment and other incidents.

The Policy and practice provide for a review of the data to use the information to identify and address any opportunities for improvement related to staff training; resident education; and policies and procedures related to sexual abuse prevention, detection and response. Review of documentation and interviews confirm that an annual report is documented and is accessible to the public. The annual report does not contain identifying information.

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.

The PREA Compliance Policy addresses this standard. The Policy and reviewed practices provides that the incident-based and aggregate data and other related documents are securely retained. The Policy also provides for the required data to be maintained for at least 10 years after the date of its initial collection unless a state, federal or local law requires otherwise and in accordance with the Lucas County Juvenile Court's record retention and destruction schedule. A review of documentation shows that all personal identifiers are removed from the annual report and the report is available to and accessible by the public on the Lucas County website.

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.

Shirley L. Turner   July 2, 2017

Auditor Signature   Date