PREA AUDIT REPORT ☐ Interim ☒ Final

COMMUNITY CONFINEMENT FACILITIES

Date of report: January 27, 2017

Auditor Information			
Auditor name: Robert Manville, Patricia Pepe			
Address: 168 Dogwood Drive, Milledgeville, GA. 31061			
Email: robertmanville9@gmail.com			
Telephone number: 912-486-0004			
Date of facility visit: 6/11 through 6/13/2016; 1/26 through 1/27/2017			
Facility Information			
Facility name: Liberty North			
Facility physical address: 1007 West Lehigh Avenue, Philadelphia, PA 19133			
Facility mailing address: *(if different from above)* 100 Rose Road, Suite 200, King of Prussia, PaA 19406			
Facility telephone number: 610-265-6700			
The facility is:	☐ Federal	☐ State	☐ County
	☐ Military	☐ Municipal	☒ Private for profit
	☐ Private not for profit		
Facility type:	☐ Community treatment center ☒ Halfway house ☐ Alcohol or drug rehabilitation center	☐ Community-based confinement facility ☐ Mental health facility ☐ Other	
Name of facility's Chief Executive Officer: Jason Starling			
Number of staff assigned to the facility in the last 12 months: 69			
Designed facility capacity: 250			
Current population of facility: 87			
Facility security levels/inmate custody levels: Community, pre-release,parole,and USPO			
Age range of the population: 21 to 65+			
Name of PREA Compliance Manager: Jason Starling		**Title:** Program Director	
Email address: jstarling@l-m-s.com		**Telephone number:** 215-227-1930	
Agency Information			
Name of agency: Liberty Management Services, Inc.			
Governing authority or parent agency: *(if applicable)* Philidephia Suburban Development Cooperation			
Physical address: 100 Rose Road, Suite 200, King of Prussia, Pa. 19406			
Mailing address: *(if different from above)* Click here to enter text.			
Telephone number: 610-265-6700			
Agency Chief Executive Officer			
Name: Mark Nicolleti		**Title:** CEO/ Co Vice President	
Email address: mnicolleti@psbc1962.com		**Telephone number:** 610-265-6700	
Agency-Wide PREA Coordinator			
Name: Jason Starling		**Title:** Director	
Email address: jstarling@l-m-s.com		**Telephone number:** 215-227-1930	

AUDIT FINDINGS

NARRATIVE

Liberty Management Services Inc. (LMS) is a private, for-profit social service company providing professional services to corrections agencies at all levels of government. The company has several enterprises, including community corrections and pre-release housing, day reporting programs for parolees and correctional facility design and development services. The company operates only two centers that falls under the requirements of The Prison Rape Elimination Act. (PREA). LMS originally contracted with PREA Solutions to conduct an audit of their community corrections operation in Philadelphia, Pennsylvania. Prior to the audit PREA solutions requested LMS allow Robert Manville a certified auditor take the lead in conducting the PREA Audit. PREA solutions shared all of their documentation with Mr. Manville. Patricia Pepe, president of PREA solutions assisted in all areas of the audit.

Prior to the onsite visit the LMS PREA compliance coordinator submitted a Pre-Audit tool and supporting documents to the auditor. Prior to the on-site visit, the auditor conducted a comprehensive evaluation of the agency policies, facility procedures, program documents, and other relevant materials.
During the on-site review the auditors toured the center during the first, second and third shift. Auditors had informal conversations with residents during the tour and found residents and staff open to conversations with the auditors. During the tours of the respective center, auditors observed amongst other things location of camera and mirrors, facility configurations, staff supervision of residents, resident entrance and search procedures and resident programming. Some of these observations can be found in the Center Description. An intake screening was observed at 9:45 A. M June 13th.

LMS provides around the clock supervision and management of Pennsylvania Department of Corrections (DOC) parole / reentry residents at their male and female centers. Although required to return to the centers at night, the majority of the residents are permitted to leave the centers during the day for employment, attendance at educational or vocational programs and development of pro-social bonds while in residence.
Offenders are generally in residence for approximately 60 days before being released on a home plan or reaching their maximum confinement period. A camera system is in operation and generally covers all center common areas. There is no camera coverage of bedrooms, bathrooms or shower rooms. The camera systems are monitored from the Accountability Reporting Center located in the basement of Lehigh North.
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During the last twelve months there have been two PREA allegations reported at the centers. One report was of staff on resident voyeurism (BOP resident) and one was resident on resident verbal sexual harassment (DOC resident). In the BOP case, the investigation is pending. In the DOC case, LMS is unaware of the investigation outcome.

Six weeks in advance of the audit several posters were hung throughout the facility announcing the upcoming audit. These posters explained the purpose of the audit and provided the residents and staff with the original auditors contact information. There were no correspondence from residents or staff.

The on-site portion of the audit was conducted over a three day period: June 11th,12th, and 13th, 2016 During this time the auditors conducted interviews with center leadership, staff and residents. The requisite interviews were conducted consistent with DOJ PREA auditing expectation in content and approach, as well as individuals selected for interviews. In addition, an extensive center tour was conducted that included all areas of both centers. During the review 14 resident and 9 line staff interviews were conducted. The center did not house any transgender or low intellectual residents. The center's PREA coordinator accommodated the auditors' request to interview random staff and residents and specific staff such a center's executive director.

Phone interviews were conducted with the President of LMS, Philadelphia Sexual Assault Response Center, Drexel University College of Medicine (Dr. Daniel V Schidlow)

During the on-site audit process, the following management staff were present for in briefing, out briefing and questions and discussions during the audit process. Monique Hendricks Executive Director; Jeanette Phillips Compliance Officer; Hesia McMickens Program Manager; and Jason Starling Program Manager/PREA compliance officer.

Description of Center

INTERIM

The center at 2900 North 17th Street, Philadelphia, PA (Liberty Phoenix) houses adult female offenders and the center at 1007 West Lehigh Avenue, Philadelphia, PA (Liberty North) houses adult male offenders. LMS provides around the clock supervision and management of both Bureau of Prisons (BOP) and Pennsylvania Department of Corrections (DOC) parole / reentry residents at their male and female centers. Although required to return to the centers at night, the majority of the residents are permitted to leave the centers during the day for employment, attendance at educational or vocational programs and development of pro-social bonds while in residence.
Within both the BOP and DOC programs offenders are generally in residence for approximately 60 days before being released on a home plan or reaching their maximum confinement period. A camera system is in operation at both sites and generally covers all center common areas. There is no camera coverage of bedrooms, bathrooms or shower rooms at either center. Both camera systems are monitored from the Accountability Reporting Center located in the basement of Lehigh North and managers at both centers have camera monitors for their respective centers in their offices.
During the last twelve months there have been two PREA allegations reported at the centers. One report was of staff on resident voyeurism (BOP resident) and one was resident on resident verbal sexual harassment (DOC resident). In the BOP case, the investigation is pending. In the DOC case, LMS is unaware of the investigation outcome.
Liberty North, is a multi–level structure that has been in operation as a community corrections site for nineteen years and has a maximum capacity of 120 male residents. Administrative offices, an intake area, control, a resident gymnasium, DOC dining area, and BOP case managers are located on the first floor. BOP residents are housed on the second floor in thirteen rooms containing between four and eight residents each. Case managers' offices are located on the third floor. DOC residents are housed on the fourth floor in seventeen rooms containing between four and eight residents each. There are bathroom / shower rooms located on both housing floors. The kitchen, dining room and Accountability Reporting Center are located in the basement and an outdoor recreation space is also on site. English and Spanish postings with a PREA hotline and mailing address were observed throughout the programing space. PREA postings regarding cross gender staff announcement on the housing floors were also observed throughout the housing floors.
Liberty Phoenix, is a multi-level structure that has been in operation as a community corrections site for three years and has a maximum capacity of seventy two female residents. An intake area, control, administrative offices, a dining area, and a classroom are located on the first floor. The second floor is not in use. BOP residents are housed on the third floor in nine rooms containing between four and six residents. The bedroom doors on this floor have large viewing windows which are partially covered by curtains. DOC residents are housed on the fourth floor in nine rooms containing between four and six residents each. The bedroom doors on this floor do not have viewing windows. A bathroom and shower rooms are located on each housing floor. There is also a classroom located on both the third and fourth floors. English and Spanish postings with a PREA hotline and mailing address were observed throughout the programing space. PREA postings regarding cross gender staff announcement on the housing floors were also observed throughout the housing floors. Each time a cross gender person was on the living area, the staff assigned that area announced their presence.

DESCRIPTION OF FACILITY CHARACTERISTICS

Click here to enter text.

SUMMARY OF AUDIT FINDINGS

During the last 12 months there has been 2 sexual abuse or sexual harassment allegations. One was from a resident and the other was from a third party. Niether resident was available for interview during the audit process. The third party allegation was investigated by Pa. Department of Community Corrections after the resident had been transferred from the center. The center was not advised on the transfer or investigative findings. The other resident was from BOP. The resident was transferred to another pre release center in Philidelphia and has been released from custody due to completion of their sentence.
The center did not have an investigative file, administrative or criminal file on these allegations.

Overall, the interviews of residents reflected that they were aware of and understood the PREA protections and the center's zero tolerance policy. While residents received initial brochures and some saw a film about PREA the center does not provide an indepth education program on PREA. All of the residents interviewed indicated they had received education had their prior center that was very indepth.

Interviews with staff indicated they had received a PREA training and could articulate the meaning of zero tolerance.

The center has a MOU with Drexel University Hospital for all medical and mental health sevices. Drexel sponsors the Philadelphia Sexual Abuse Response Center which is not located at the hospital but in close proximity to the Philedephia Policy Special Response Center. According to the PSARC there is a full time SANE nurse available 24 hours a day seven days a week

FINAL REPORT: The center has modified the program operations and made major modifications in staff and housing of residents. (See Program Description) A corrective action plan was developed for areas of non compliance along with an interim report. The initial follow up conference call was conducted on July 21, 2016 After follow up emails to the Executive Director Ms. Monique Hendricks at that time went unanswered a formal letter was sent to the Ms. Hendricks on August 15, 2016 which was also received no response. On October 11, 2016 sent an email from Jason Sterling advising the center had undergone significant changes. The center no longer was housing BOP residents and had condenced all programs and has placed all resident into one building. Mr Sterling shared his commitment to operating a center that complies with all PREA standards. Several new policies were attached to the email along with modifications to other policies and program modification and enhancement. Other polices and training files have been furnished during CAP period. All policies comply with PREA standards. During the follow up review on January 26-27, 2017 interviews with staff, documentation found in training records, review of all policies and procedures found the center had completed all of the issues raised in the original and followup CAP. Mr. Starling indicated and it was determined by review of documents the center follows all of the contractual requirements with PA. Department of Correction Bureau of Community Corrections BCC-ADM 008 PREA Manual. The center Director continues to serve as the PREA Compliance Manager during the CAP. A new PCM has been identified and is undergoing training prior to assuming this role.
The center is in compliance with PREA.

Number of standards exceeded: 1

Number of standards met: 35

Number of standards not met: 0

Number of standards not applicable: 3

Standard 115.211 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.

Interim Report

Liberty Management Services has implemented a zero tolerance policy as detailed in Policy which comprehensively addresses the agency's approach to preventing, detecting, and responding to all forms of sexual abuse and sexual harassment. The policy contains necessary definitions, sanctions and descriptions of the agency strategies and responses to sexual abuse and sexual harassment. This policy forms the foundation for the program's training efforts with residents, staff, volunteers, contractors, and others. The agency has designed a PREA Coordinator, Mr. Jason Starling. His official title is Program Director and PREA Coordinator. The PREA Coordinator reports directly to the Executive Director of LMS. Mr. Starling indicates that he has sufficient time and authority to develop, implement, and oversee the agency efforts toward PREA compliance. There are sufficient posters to remind staff and residents of zero tolerance. Staff and resident interviewed indicated their understanding and could provide most of the component definitions.

Policy, Materials, Interviews and Other Evidence Reviewed

 Completed Pre-Audit Questionnaire
 Interview with chief of security
 Interview with shift supervisors
 Interview with PREA coordinator
 Interview with resident
 Interview with random staff
 Review of intake pamphlet
 Observations of Posters

Final Report

Liberty Management Services has implemented a zero tolerance policy as detailed in Policy PE 2 – 4.3 which comprehensively addresses the agency's approach to preventing, detecting, and responding to all forms of sexual abuse and sexual harassment. The policy contains necessary definitions, sanctions and descriptions of the agency strategies and responses to sexual abuse and sexual harassment. This policy forms the foundation for the program's training efforts with residents, staff, volunteers, contractors, and others. The agency has assigned a PREA Coordinator, Mr. Jason Starling. His official title is Program Director and PREA Coordinator. He also presently services as the PREA Complaince Manager for Liberty North. The PREA Coordinator reports directly to the CEO of LMS. Mr. Starling indicates that he has sufficient time and authority to develop, implement, and oversee the agency efforts toward PREA compliance. There are sufficient posters to remind staff and residents of zero tolerance. Staff interviewed indicated their understanding and could provide adequate definition of all PREA Zero Tolerance Standards.

Standard 115.212 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.

Not Applicable The center does not contract with other entities

Standard 115.213 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)

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LMS does not have a formalized, written staffing plan that addresses the mandatory eleven elements and consideration required in this PREA standard. Interviews with the Program Managers and Chief of Security established that the center does have a level of supervision that management expects supervisors to maintain. Supervisors were aware that certain number of staff were required to be present at all times. The center does not have a formalized policy that requires a stringent staffing plan that includes overtime policies, hold over of staff and reporting of staffing problems up the chain of command. There has not be a review of any of the staffing plans or needed staff.

 Completed Pre-Audit Questionnaire
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 Interview with shift supervisors
 Interview with PREA coordinator
 Interview with Executive Director

Correction Action Plan Required

The center will develop a staffing policy to cover all components of PREA
The center will review the staffing plan, camera coverage and incidents review to determine if additional staffing is required
The center will develop a policy that requires all administrative staff to make frequent unannounced visit to all areas of the center.

The center has modified the operations and moved all residents to one building. As part of the movement the center completed a new staffing plan. Gender specific staff are assigned to the female floor as well as being available for new intakes and female/ transgender pat searches. The center requires an expected number of staff by gender to be present at the center at all times. The center staff indicated there is no problem in holding over or asking staff to come back to the center. A review of center's staffing for the month of December validated this practice. Administrative staff are required to make frequent rounds on all floors. A sign in folder is maintained on each floor for administrative to document they visited each living area. Documentation was found to be in compliance with the standard. The center's staffing plan requires two person on each floor at all times. This seems to be a suffiecinet number of staff to manage the center's operations. Additionally, center staff indicated they are required to have female staff on duty at all times. The center reviewed all cameras and other montoring prior to modifying present program. The center had no PREA allegations that affected center operations and required consideration and developing the present staffing plan. Policy PE.2-4.1 Sexual Abuse Review Policy requires that the Sexual Abuse Review Team review the staffing level, montoring equipment and physical plant after any allegations of abuse and make recommendation to the PCM and CEO of Liberty Management Services.

Standard 115.215 Limits to cross-gender viewing and searches

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

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

The LMS policy prohibits cross-gender strip searches when possible. LMS policy also prohibits staff from performing intrusive or invasive body cavity searches under all circumstances; staff is permitted to do a visual inspection of a resident's mouth cavity only. Cross-gender pat searches are authorized when a supervisor is in the area. The center does not have a policy of searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status.
LMS ensures that residents are able to shower, perform bodily functions, and change clothing with privacy. Policy and practice require announcement when staff of the opposite gender enter the housing unit and the shower/toilet area. Interviews with residents and staff confirm this as the policy and actual practice of the program on a consistent basis.
LMS reports that it has conducted no cross-gender strip or cross-gender visual body cavity searches of residents in the last 12 months. The agency has provided training to staff regarding how to conduct cross-gender pat down searches.

Policy, Materials, Interviews and Other Evidence Reviewed

- Completed Pre-Audit Questionnaire
- Interview with chief of security
- Interview with shift supervisors
- Interview with PREA coordinator
- Interview with Executive Director
- Review of Search Policy
- Observation of Intake

Corrective Action Plan Required

The center should revise search policy that prohibit cross gender searches except in exigent circumstance..

The center should provide same gender staff to conduct pat searches when possible.
The center should develop a policy on trans gender and intersex residents that includes all requirement of PREA to include determination of gender identification which is not solely based on strip searches.
Staff will require training on the above policies.

FINAL

The center does not allow cross gender strip or cross gender visual body cavity searches. The center does not allow male staff to search female residents. Interviews with staff indicated that male staff can not search female residents and can only search transgender residents when the transgender residents identifies as male and requests that a male staff conduct pat searches and then only with the Center's directors approval. The center director indicated he would contact BCC prior to authorizing transgender pat searches. The center has developed and trained staff on Policy PE-2-2-4.1 Transgender Reentrant/Resident Placement and Intake that includes all areas of a transgender residents identification, intake and searches. Policy specifically states that transgender residents will not be searched for the purpose of determining resident's genital status. Center policy CS – 4.6 establishes resident have the right to shower, dress and perform bodily functions in private. All staff interviewed indicated that they understood these requirements. Staff announce their presence when entering a cross gender living unit and again prior to entering cross gender rooms. All staff interviewed indicated they had received training on conducting trans gender searches.

Standard 115.216 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.

Interim Report

The LMS policy requires the program to ensure residents with special needs have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect and respond to sexual abuse and harassment. The center has staff assigned to each shift that are bilingual in Spanish and English. The center has access to Language Services and with Philadelphia services for the deaf and blind.

The LMS policy requires the program to ensure residents with special needs have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect and respond to sexual abuse and harassment. The center has staff assigned to each shift that are bilingual in Spanish and English. The center has access to Language Services and with Philadelphia services for the deaf and blind.
The center does not have a formal policy that prohibits the use of residents/clients as interpreters when dealing with first responder situations or any allegation/investigations of sexual abuse or harassment. PREA posters and brochures are

located throughout the facility in English and Spanish. The LMS reports that there have been no instances in the past 12 months where resident interpreters have been used.

Policy, Materials, Interviews and Other Evidence Reviewed

 Completed Pre-Audit Questionnaire
 Interviews with (PREA Coordinator
 Interview with Compliance Officer
 Interviews with random facility staff and residents.
 Samples of PREA poster and brochure translated into Spanish
 PREA Training Materials for resident education

Corrective Plan Required

The center does not have a policy specifically prohibiting the use of other residents as translaters . However, all staff indicated that the center had a practice not use other residents. Center needs to codify practice in policy.

Final:

The LMS policy PE 2-4.5 Special Needs requires the program has staff assigned to each to assure residents with special needs have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect and respond to sexual abuse and harassment. The center has staff assigned to each shift that are bilingual in Spanish and English. The center has access to Language Services and with Philadelphia services for the deaf and blind.

The center Policy PE 2-4.5 prohibits the use of residents/clients as interpreters when dealing with first responder situations or any allegation/investigations of sexual abuse or harassment. PREA posters and brochures are located throughout the facility in English and Spanish. The LMS reports that there have been no instances in the past 12 months where resident interpreters have been used. Staff interviews indicated that there are sufficient number of bilingual staff to provide translation services.

Standard 115.217 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.

Interim Report

All employees, contractors, and volunteers have had their background checks completed through Federal Bureau of Prisons prior to offering employment. The center has a tracking system to ensure all staff receive background checks every five years. Staff policy are required to report all arrests. Policy states false information submitted by applicants is grounds for

termination. The center does not have a policy or practice to complete background checks or consider substantial sex abuse allegations prior to promotions.

Policy, Materials, Interviews and Other Evidence Reviewed

 Completed Pre-Audit Questionnaire
 Interviews with PREA Coordinator
 Interview with Executive Director
 Interviews with Human Resources staff
 Review of personnel Files

Corrective Action Required

The center should revise policy to require background checks prior to any promotion.

Final:

All employees, contractors, and volunteers have had their background checks completed prior to offering employment. The center has a tracking system to ensure all staff receive background checks every five years. Staff policy require staff to report all arrests. The center has added a question to the pre employment of promotion questionnaire that asks if the person being considered has had any violations of the PREA act. Policy states false information submitted by applicants is grounds for termination. The center Policy PE2-2.4 Personel policy requires that a back ground check and PREA questionnaire must be completed on all employess prior to promotions.

Standard 115.218 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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Interim Report

Through interviews with LMS President, Executive Director and Center Program Managers it was demonstrated that the agency considers resident supervision and monitoring is a key part of all upgrades to the center. Presently LMS is reviewing another site for moving the present programs. The agency has secured the services of a monitoring company to design a camera system to comply with all aspects of PREA.

Final

Through interviews with LMS President, Executive Director and Center Program Managers it was demonstrated that the agency considers resident supervision and monitoring is a key part of all upgrades to the center. Prior to moving all residents to one building the executive team reviewed all monitoring equipment to determine if it met the needed level of survelance. .

Policy, Materials, Interviews and Other Evidence Reviewed

 Completed Pre-Audit Questionnaire
 Interviews with (PREA Coordinator
 Interview with Company President
 Camera mapping for present and future center

Standard 115.221 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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FINAL

LMS refers all allegations regarding sexual assault to BCC) and to the local police department for criminal investigation purposes. The center utilizes Drexel Teaching Hospital for emergency services including sexual assaults. Drexel Teaching Hospital has an agreement with Philadelphia Sexual Abuse Center. Included in the centers protocol is a SANE/SART program. The center also provides rape crisis service to victims of sexual assault. LMS has Posters though out the center providing information on the service provided by the Philadelphia Sexual Abuse Center. By contractual agreement LMS must report all allegations of abuse or harassment to the BCC contracting officer for all allegations for resident referred to the center by the State of Pennsylvania. LMS conducts an internal investigation of employee misconduct that does not rise to a PREA incident. However, Pa. Department of Corrections conducst investigation of all sexual abuse or harassment complaints. The center has a MOU with the Women Organized Against Rape Advocacy to provide counseling, support and accompany victims throught the forensic examination process and well as providing crisis intervention, information and referrals.
The center policy PE 2-4.1 First Responders provides staff guidance on crime scene preservation and victims supervision and support. All staff indicated they had receive First Responder Training and understood their role which included appropriate notifications and supervision.

Policy, Materials, Interviews and Other Evidence Reviewed

 Completed Pre-Audit Questionnaire
 Interviews with PREA Coordinator
 Interview with Compliance Officer
 Interview with Philadelphia Sexual Assault center
 Copy of contracting agreement with BOP and Pa. Correctional Contracting Staff
 Interview with Drexal Medical Center

Standard 115.222 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)

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Interim

The center has a contractual agreement with Pa. Department of Corrections Contracting Office and BOP Contracting Officers to forward all allegations to their office to determine investigative levels. However the center does not have a policy that specifically requires policies that all allegations will be investigated. The two incidents during the last year were treated differently One incident was reported by a third party to the PA. Hotline. The resident was moved to another center by PDOC and the center was advised of this action and that an investigation had occurred. The other allegation was referred to BOP who asked the center to investigate the incident. The investigations was ongoing during the on-site review.

Policy, Materials, Interviews and Other Evidence Reviewed

 Completed Pre-Audit Questionnaire
 Interviews with PREA Coordinator
 Interview with Compliance Officer
 Copy of contracting agreement with BOP and Pa. Correctional Contracting Staff

Corrective Action Required

The center should engage in conversation with contracting offices with BOP and Pa. Department of Corrections to formulate a local policy that allows centers to refer all allegations for investigation.

Final:

The center has developed and implemented policy P.E-2-4-1 Investigative Reporting Policy that provides referral of all allegations to the appropriate persons. Contractually the center must forward all allegations to the PA. Department of Corrections Cummunity Programs for investigations. BCC has policies and protocol for all investigation conducted in private contract centers that govern investigations as required by PREA standards. The center has policy that requires they attempt to have copy of investigation forward to the Center for inclusion in the investigative files.

Standard 115.231 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)

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LMS requires all new employees to have in-depth training on PREA and Sexual Harassment in the Workplace. Annual refresher training on PREA is also required for all employees. A review of the PREA training materials shows training on the eleven specific topics found in the standard. The facility reports that all staff have been trained on PREA. All staff is required to sign the PREA Acknowledgement Form stating they have received the PREA training and understand their responsibilities therein. All staff interviewed were able to articulate the topics required in the staff training.

Policy, Materials, Interviews and Other Evidence Reviewed
 Completed Pre-Audit Questionnaire submitted by SCYP
 PREA Training at Academy for new DOC Employees
 LMS Training Plan
 Review of random staff personnel files and training records
 Interviews with random staff regarding their PREA training and knowledge;
 PREA Acknowledgement Form for employees

Standard 115.232 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.

FINAL

LMS requires all new volunteer and contractors to have training on PREA and Sexual Harassment in the Workplace. Annual refresher training on PREA is also required. A review of the PREA training
Materials shows training on the eleven specific topics found in the standard. The facility reports that all contractors and volunteers have been trained on PREA. All volunteers and contractors are required to sign the PREA Acknowledgement Form stating they have received the PREA training and understand their responsibilities therein. The center does not have any volunteers at this time.

Policy, Materials, Interviews and Other Evidence Reviewed
 Completed Pre-Audit Questionnaire submitted by SCYP

 LMS Training Plan
 Review of random volunteer and contractor's training records
 Interviews with random contractors and volunteer regarding their PREA training and knowledge;
 PREA Acknowledgement Form for contractors and volunteers.

Standard 115.233 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.

All residents assigned to LMS are provided PREA orientation materials at intake. Staff interviewed indicates that intake education normally happens on the first day the resident is admitted to the SCYP. They are provided the SCYP Client Handbook which includes the PREA. These documents provide detailed information about PREA, the agency's zero tolerance policy, key definitions of certain conduct, how a youth can protect themselves, and how to report sexual abuse or harassment. The information can be provided in other languages via the program's contracted translation service if necessary. Visually impaired residents would be provided all PREA information orally from the counselor should the program accept such a resident. Residents sign the PREA Client Acknowledgement Form to demonstrate they have received PREA training and they understand their rights under PREA and specifically understand the ways they can report sexual abuse and sexual harassment.The facility ensures key information about PREA is continuously and readily available and visible to residents. LMS displays PREA posters in common areas of the facility with the abuse hotline number in bold print. Posters are displayed in English and Spanish. PREA brochures in English and Spanish are also available at bulletin board areas in the facility. The facility provides translation services for all PREA educational materials. Two time each day the center conducts a PREA awareness announcement to all residents and staff detailing the centers zero tolerance and reporting procedures for all PREA related incidents. The reception maintains a log to document these announcements. The center has implemented the recommendation from the initial audit.

Policy, Materials, Interviews and Other Evidence Reviewed

 Completed Pre-Audit Questionnaire submitted by SCYP
 LMS Intake documentations
 Review of random resident files.
 Interviews with random case managers regarding their PREA training and knowledge;
 Interviews with random residents regarding their PREA training and knowledge

Corrective Action Recommendation

Resident interviewed indicated they did not receive any formal education outside of the intake process. All resident came from other facilities and had received education at those facilities. It is recommended that the center develop a training program or conduct focus groups with new residents to discuss sexual abuse and harassment.

Standard 115.234 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.

Interim Report

Presently, the center must advise the contracting office for BOP and PDOC prior to completing any investigations. The center utilizes the Philadelphia Police Department for all criminal investigations. When asked to conduct an investigation LMS utilizes the Center compliance officer. While she has a vast amount of investigative training, as self-reported she has not received any training specific to Sex abuse or harassments.

Policy, Materials, Interviews and Other Evidence Reviewed

 Completed Pre-Audit Questionnaire
 Review of contracting documents
 Interviews with Company executive director
 Interviews with center compliance officer

Corrective Action Required

The center needs to develop a comprehensive policy on sex abuse and sexual harassment investigations
The center need to secure specialized training for center based investigator(s)

Final

The center has developed and implemented policy P.E-2-4-1 Investigative Reporting Policy which includes all allegation of abuse to DOC for investigation The center's PREA coordinator has been trained in conducting administrative investigation and reporting procedures through the PA DOC.

Standard 115.235 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.

Not-Applicable The facility doesn't provide onsite medical or mental health care. The facility has a memorandum of understanding with Drexel University Teaching Hospital for medical services and with the Philadelphia Sexual Abuse Center for follow up and mental health treatment

Policy, Materials, Interviews and Other Evidence Reviewed

 Completed Pre-Audit Questionnaire
 Interview with staff from Philadelphia Sexual Abuse Center (PSAC)
 Interview with staff from Drexel University Teaching Hospital
 Information provided by PREA Coordinator
 Posters provided by PSAC

Standard 115.241 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 center does not have a policy governing screening nor does it have a screening instrument for risk of victimization and abusiveness.
Contractually, the center relies on information provided by BOP and PDOC for determination of victimization and abusiveness.

Policy, Materials, Interviews and Other Evidence Reviewed

 Completed Pre-Audit Questionnaire.
 Intake packet
 Interviews with counselors who do intake.
 Interviews with PREA Coordinator
 Interview with Compliance Officer

Corrective Action Required

Center must develop a policy requiring screening of new residents and follow-up screening after sexual abuse incidents
Center must adopt a screening instrument to be used for screening for sexual victimization and abusiveness

Final

The center has developed appropriate policies and screening instruments for all new arrivals. There is a screening instrument for intake staff for all new arrivals and also a medical screening instrument that intake ask new residents upon their arrival at the center. The center adopted the PA DOC screening instrument that includes all aspects required under this standard. Interviews with staff and review of screening documents verified that all residents have beens screened and screening occurred with 72 hours of being assigned to the center and within 30 of being housed at the center. Staff indicated that residents can be reassessed at other times when appropriate. Staff indicated they do not require resident answer questions and no resident is sanctioned for not answering or refusing to submit to screenings.

Standard 115.242 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 center does not have a screening instrument or any policies on how to use information gathered. The center does not have a housing plan. Residents are assigned to different areas and centers based on gender and contracting agency.

Policy, Materials, Interviews and Other Evidence Reviewed

 Completed Pre-Audit Questionnaire.
 Intake packet
 Interviews with counselors who do intake.
 Interviews with PREA Coordinator
 Interview with Compliance Officer

Corrective Action Required

The center needs to develop a screening program that includes policy, instrument, and purpose of instrument. Intake staff will need to be trained on use of the instrument in housing residents. Each screening should be used to determine the individual needs of the residents and should take into consideration the resident feeling of safety.

Final

The new screening instrument is used for placement of residents. This includes housing vulnerable persons closer to staff and closer to the door in multi occupancy bedrooms. The center coordinates with BCC. on placement of assaultive or predator residents. Staff interviews indicated there was designated bedrooms on each floor to house vulnerable residents.
Policy PE2-4.1 Transgender Placement and Intake requires that housing take into consideration residents health and safety and whether the placement would present management problems. The residents own views will be given serious consideration prior to determining housing options.

Standard 115.251 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.

LMS provides residents multiple internal ways to report sexual abuse and sexual harassment, retaliation, and staff neglect. Residents receive education about reporting at intake, and through visible and available information in the facility at all times. The center conducts a daily briefing to all residents that include reporting methods. The reporting methods include verbally telling a staff member, medical staff, volunteer, contractor or the PREA Compliance Manager; calling the abuse hotline; submitting a written grievance; having a third-party submit an oral or written complaint on the resident's behalf; residents may call PSAC and number is provided for such a call. Residents are allowed the use of cell phones and work off-site. The center also provides a bulletin with information on contacting Women Organized Against Rape for resident to contact this organization. All staff interviewed indicated that any resident reporting must be kept confidential.

Policy, Materials, Interviews and Other Evidence Reviewed

 Completed Pre-Audit Questionnaire.
 Interview with PSAC
 Interviews with random residents.
 Interviews with PREA Coordinator
 Interview with Compliance Officer
 Observation of sex abuse hotline Posters for BOP and PDOC
 Observation of Posters provided from PSAC

Standard 115.252 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 Center reports there have been no grievances or emergency grievances have been filed alleging sexual abuse or sexual harassment in the past 12 months. The Center has a formalized grievance policy. The Residents Handbook informs residents

of the grievance process that does not pose time limits on filing a grievance. The information provided by PDOC to new residents advises them of their right to notify the hot line at any time during their stay or anytime they have been discharged or transferred from the center. The center grievance boxes are locked. The center director is the only staff allowed to open these boxes. The center has modified a section on their grievance forms to include additional notification regarding Sexual Abuse or Harrassment.

Policy, Materials, Interviews and Other Evidence Reviewed

- Completed Pre-Audit Questionnaire.
- Review of information provided by BOP and PDOC
- Interviews with random residents.
- Interviews with PREA Coordinator
- Interview with Compliance Officer
- Observation of sex abuse hotline Posters for BOP and PDOC
- Observation of Posters provided from PSAC.

Standard 115.253 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 center utilizes Drexel University College of Medicine Philadelphia Sexual Assualt Response Center to provide access to confidential support services. The center also has a MOU with Women Organized against Rape. Resident are given information about the center during orientation and Poster are displayed throughout the center discussing their services. Residents may call the center or drop by the center anytime they are on an authorized pass. The center provides support on a continuous basis during the residents stay and after the resident is released from the center.

Policy, Materials, Interviews and Other Evidence Reviewed

- Completed Pre-Audit Questionnaire.
- Interviews with random residents.
- Interviews with PREA Coordinator
- Interview with Compliance Officer
- Interview with PSAC staff
- PSAC Posters

Standard 115.254 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.

Interim Review.

The center provides residents during orientation with brochure that includes BOP and PDOC hotline that they may share with other persons. Volunteers are told they may notify BOP and PDOC of any incidents. One of the two incidents that were reported one was by a third party. The center does not have a formal program or policy to manage third party reporting.

Policy, Materials, Interviews and Other Evidence Reviewed

 Completed Pre-Audit Questionnaire.
 Review of information provided by BOP and PDOC
 Interviews with random residents.
 Interviews with PREA Coordinator
 Interview with Compliance Officer
 Observation of sex abuse hotline Posters for BOP and PDOC

Corrective Action Required

The center must develop a reporting policy that includes third party reporting. The present Web site should be revised to include information on how to report sex abuse or harassment. The public must be made aware of how to report information

Final

The center has developed a policy PE 2-4.0 on reporting and has trained staff on all reporting including their ability to provide confidential reporting as a third party. LMS has added reporting procedures on the company web site www.lms1995.com which includes how to report information directly to the company. Residents are allowed to go outside the center within 24 hours of arriving at the center and are provided how to utilized the Women Organized Against Rape to report on their behalf.

Standard 115.261 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.

All LMS staff is required to immediately report any suspected or alleged abuse, harassment or neglect to the appropriate supervisor, PREA coordinator and Center compliance officer.
Policy PE 2-4.0 Reporting includes all element required by this standard.
The agency's PREA policy states that retaliation will not be tolerated and explicitly requiring staff to report any suspected or known retaliation against residents or staff. All staff were aware of the requirements to report and have received training on reporting. The center has implemented a first responder policy that also includes mandates for staff reporting allegations of sexual abuse or harassment.
All staff interviewed were aware of their reporting duties and the requirement that all reports be kept confidential. There were some descrepancies in who staff should provide reports that needs to be clarified for some of the staff hired in last 60 days.

Policy, Mavbterials, Interviews and Other Evidence Reviewed
 LMS PREA Policy
 Completed Pre-Audit Questionnaire
 Interview with PREA Compliance Manager
 Interviews with random sample of staff
 PREA Handout

Standard 115.262 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.

LMS reports that there have been no situations in the past 12 months where the facility determined a resident was subject to substantial risk of imminent sexual abuse. Review of policy and interviews with the PREA Coordinator and Supervisors demonstrated the protective measures that would be taken in the event it was found that a resident was at imminent risk of sexual abuse. The center has two centers to house residents and contracting officer can authorize the movement of residents to other centers on very short notice.

Policy, Materials, Interviews and Other Evidence Reviewed

 LMS PREA Policies:
 Completed Pre-Audit Questionnaire
 Interviews with random sample of staff
 Interview with PREA Compliance Manager

 Interview with Center Compliance Officer
 Interview with Center Executive Director

Final

The center has closed one center and combined programs. There is a formal grievance process as well as a requirement for reporting any allegation of sexual abuse or harassment. The center has issued a First Responder policy and trained staff first responder duties. Staff have been trained on how to protect residents that are at imminent danger and to notify the center director immediately. The center director advised that by contract requirements he must notify BCC to get further directions. All staff interviewed were able to articulate there understanding of protection of residents.

Standard 115.263 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 center does not interview new residents about prior abuse or harassment and does not have a policy to address how to handle this information. The compliance officer and executive director indicated they would notify their contracting officer.

Policy, Materials, Interviews and Other Evidence Reviewed

 Completed Pre-Audit Questionnaire
 Interviews with random Shift Supervisor
 Interview with PREA Compliance Manager
 Interview with compliance officer
 Interview with executive director

Corrective Action Plan Required

As part of the screening instrument the center should ask new residents of past experiences of harassment. This information should be shared with the sending facility.

Final:

The center has implemented an intake system that includes asking resident about prior abuse or harassment. The policy requires that the staff advise the PREA coordinator whom will notify the agency contracting to house residents at the center and also the facility where the allegation originated.

Standard 115.264 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 center does not have a comprehensive first responder policy. The PREA training includes first responder duties but staff interviewed revealed a lack of understanding on first responder duties.

Policy, Materials, Interviews and Other Evidence Reviewed

 Completed Pre-Audit Questionnaire
 Interviews with random Shift Supervisor
 Interview with PREA Compliance Manager
 Interview with compliance officer
 Interview with executive director

Corrective Action Required

The center should develop a policy for first responder and retrain all staff on first responder duties. Other consideration should be given to providing staff with a laminated index card with first responder duties.

Final:

The center has developed, implemented and trained staff on Policy PE 2-4.1 First Responder that details action that staff will separate residents, preserve the crimes scene including the residents and/or staff involved to the extent possible. Staff interviews indicated they had this training and were able to articulate their understanding of the policy.

Standard 115.265 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.

Interim Report:
The center does not have a comprehensive first responder policy The PREA training includes first responder duties but staff

interviewed revealed a lack of understanding on first responder duties.

Policy, Materials, Interviews and Other Evidence Reviewed

 Completed Pre-Audit Questionnaire
 Interviews with random Shift Supervisor
 Interview with PREA Compliance Manager
 Interview with compliance officer
 Interview with executive director

Corrective Action Required

The center should develop a policy for first responder and retrain all staff on first responder duties. Other consideration should be given to providing staff with a laminated index card with first responder duties.

Final

The center has develop and implemented a comprehensive first responder policy. The center provided a sign in roster to verify that all staff have received training on the new policy. As part of the policy the center has established a system for a coordinated response to PREA incidents. The center includes a first responder checklist that includes all areas of coordination as well as a requirement to complete a DOC required reporting document. Interviews with staff validated this training.

Standard 115.266 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.

The center has a policy that all staff accused of sexual abuse, harassment or neglect will be place on leave with pay or moved to the other center depending on the severity of the allegation The center has an agreement with the contracting officer to move accused resident to other centers pending investigation.

Policy, Materials, Interviews and Other Evidence Reviewed

 Completed Pre-Audit Questionnaire
 Review of personel policy and contract agreement
 Interview with PREA Compliance Manager
 Interview with human resouceds staff

 Interview with executive director

Standard 115.267 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.

LMS reports that in the past 12 months there have been zero incidents of retaliation reported, known or suspected. The Center's PREA policy clearly states that retaliation against any resident or staff member that reports sexual abuse or participates in an investigation is not tolerated. There had been no local investigations and not residents that had made any allegations were present, therefore the auditor was not able to provide any further verification of compliance.
The agency reports that the designated staff member charged with monitoring retaliation is the Sexual Assault Prevention/Intervention Coordinator and that the requirements of this standard would be met in the event an allegation or suspicion of retaliation. Interviews with key leadership staff indicate the requirements of this standard would be met in the event the agency does gain knowledge, suspicion or an actual allegation of retaliation. Center policy PE – 4.2 Agency Protection against Retaliation includes all elements required by this standard.

Policy, Materials, Interviews and Other Evidence Reviewed

 Completed Pre-Audit Questionnaire
 Review of personel policy and contract agreement
 Interview with PREA Compliance Manager
 Interview with human resouces staff
 Interview with executive director

Standard 115.271 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.

N/A According to Director and review of contract documents it was determined that center does not conduct its own investigation.

Policy, Materials, Interviews and Other Evidence Reviewed

□ Completed Pre-Audit Questionnaire
□ Review of contract agreement
□ Interview with PREA Compliance Manager
□ Interview with human resouces staff
□ Interview with executive director

Standard 115.272 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.

LMS reports that they use a lower standard of proof below a preponderance of the evidence for determining whether allegations of sexual abuse or sexual harassment are substantiated. Interviews with Center Director- PREA coordinator confirmed compliance with this standard.

Policy, Materials, Interviews and Other Evidence Reviewed

□ Completed Pre-Audit Questionnaire
□ Review of contract agreement
□ Interview with PREA Compliance Manager
□ Interview with center's compliance officer/investigator
□ Interview with executive director

Standard 115.273 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.

Interim Report

LMS reports the center does not provide information to residents after investigation is completed. On the one founded investigation the resident had been moved to another center and the contract officer advised the center that they would provide the notification.

Policy, Materials, Interviews and Other Evidence Reviewed

- Completed Pre-Audit Questionnaire
- Interview with chief of security.
- Interview with PREA Compliance Manager
- Interview with human resources staff
- Interview with executive director

Corrective Action Required

The center should develop a policy to make certain that the resident victim is informed of an investigation outcome

Final

The center has developed and implement a policy PE2-4.0 Investigative Reporting Policy requires the center to notify residents of the outcome of all investigations. The policy includes that the center will request the investigation outcome from the Pa. BCC for the purpose of advising the resident.

Standard 115.276 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.

LMS PREA policy requires that staff be subject to disciplinary action up to and including termination of employment for violations of PREA requlations. The agency Code of Ethics also requires disciplinary action up to and including termination for violations. The LMS Discipline Policy provides for progressive discipline of staff. Based on interview with the center director, allegations of any criminal activity is reported to the local law enforcement.

Policy, Materials, Interviews and Other Evidence Reviewed

 Completed Pre-Audit Questionnaire
 Review Personnel Policy
 Review of PREA Policy
 Interview with PREA Compliance Manager
 Interview with human resources staff
 Interview with executive director

Standard 115.277 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 agency PREA policy requires that volunteers and contractor be subject to disciplinary action up to and including termination of access to the center for violations of sexual abuse, harassment or sexual misconduct. All volunteers and contractors sign and acknowledge statement indicating their understanding of this standard. According to the Center Director, all criminal activity of volunteers or contractors are reported to local law enforcement.

Policy, Materials, Interviews and Other Evidence Reviewed

 Completed Pre-Audit Questionnaire
 Review Volunteer Policy
 Review of PREA Policy
 Interview with PREA Compliance Manager
 Reviewed volunteer acknowledgement statement.
 Interview with volunteer

Standard 115.278 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.

Interim Report

LMS reports that in the past 12 months there have been zero administrative findings of resident-on-resident sexual abuse at the facility; additionally, the SCYP reports there have been zero criminal findings of guilt for resident-on-resident sexual abuse in the past 12 months. The facility operates as a community based prerelease center and does not have the option of isolating residents. LMS has a formalized discipline policy applicable to residents that is followed. Agency practice prohibits all sexual activity between residents. The facility reports that residents that commit PREA-related abuse or harassment would be removed from the program. However, the various policies on resident discipline do not adequately address the disciplinary process to consider all aspects required for compliance with PREA. The policy is mute on determining if the person involved in a PREA violation was coerced prior to imposing discipline. Because there have been no incidents where residents were disciplined for PREA-related conduct, the auditor could not interview anyone and no documentation exists to review.

Policy, Materials, Interviews and Other Evidence Reviewed

- Completed Pre-Audit Questionnaire
- Review Disciplinary Policy
- Interview with random staff
- Interview with PREA Compliance Manager

Corrective Action Required

The center should revise the Disicplinary Policy to include all requirements of PREA.

Final

LMS reports that in the past 12 months there have been zero administrative findings of resident-on-resident sexual abuse at the facility; additionally, the center reports there have been zero criminal findings of guilt for resident-on-resident sexual abuse in the past 12 months. The facility operates as a community based prerelease center and does not have the option of isolating residents. LMS has a formalized discipline policy applicable to residents that is followed. Agency practice prohibits all sexual activity between residents. The center operates Rule Violation Program under the direct guidance of PA BCC which requires residents can only be charges with sexual contact with staff when it is a finding that the staff did not consent to such contact. It also stipulates that resident are subject to disciplinary action for sexual activity between other residents only after a finding that the resident was not coerced.

Standard 115.282 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 center has a contract with Drexel University Medical Center and with Philadelphia Sexual Abuse Center. The Director and Compliance officer indicated that resident are taken to Drexel for all emergency treatment. Drexel indicated they would

provide emergency care and would also provide emergency mental health services. PSAC has sex abuse protocol that includes follow up treatment for all victims of sex abuse.

Policy, Materials, Interviews and Other Evidence Reviewed

 Completed Pre-Audit Questionnaire
 Interview with Drexel Medical Center
 Interview with PSAC
 Interview with PREA Compliance Manager

Standard 115.283 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.

Interim

The center provides follow up service for victims through the Philadelphia Sexual Abuse Center and Drexel University Medical Center. There is no policy nor are there any service offered to the abuser.

Policy, Materials, Interviews and Other Evidence Reviewed

 Completed Pre-Audit Questionnaire
 Interview with Drexel Medical Center
 Interview with PSAC
 Interview with PREA Compliance Manager

Corrective Action Required

The center should develop a policy that would outline what the expectation are to provide follow up service for both the resident victim and abuser. Due to the length of stay at the center the follow up should occur the remainder of the time resident is assigned to the center.

Final

The center has developed a policy PE 2- 4.4 Sexual Abuse Continued Care Policy that outlines expectation are to provide follow up service for both the resident victim and abuser.

Standard 115.286 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 center has an informal system for reviewing all incident reports. The executive director and PREA coordinator indicated the center did not have a specific policy to address this standard.

Policy, Materials, Interviews and Other Evidence Reviewed

 Completed Pre-Audit Questionnaire
 Interview with Executive Director
 Interview with Compliance Officer
 Interview with PREA Compliance Manager

Corrective Action Required

The center should develop a policy that would establish a review team and the role of the review team when a sexual abuse, harassment or neglect is substantiated. This policy to capture the need to review any needs to revise areas noted in the PREA standards

Final: The center has implemented a policy PE 2- 4. 7 and trained staff on completing an incident review on all allegations regardless of the findings. This policy contains all of the requirements of this PREA standard.

Standard 115.287 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 center does not have a policy or system in place to gather and utilized data from incident reports to improve the operation of the center to provide for a safer place for staff and residents.

Policy, Materials, Interviews and Other Evidence Reviewed

 Completed Pre-Audit Questionnaire
 Interview with Executive Director
 Interview with Compliance Officer
 Interview with PREA Compliance Manager

Corrective Action Required

The center should develop a policy that would establish a system to collect and analyses data to improve the operations of the centers.

Final

The center has developed a system for the collection of all data and reviewing data at the end of each fiscal year. The center meets on a quarterly basis to review any PREA incidents. This report is submitted to DOC for review.
Each incident is loged using a form generated by BCC that includes all required information.

Standard 115.288 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 center does not have a policy or system in place to gather and utilized data from incident reports to improve the operation of the center to provide for a safer place for staff and residents.

Policy, Materials, Interviews and Other Evidence Reviewed

- Completed Pre-Audit Questionnaire
- Interview with Executive Director
- Interview with Compliance Officer
- Interview with PREA Compliance Manager

Corrective Action Required

The center should develop a policy that would establish a system to collect and analyses data to improve the operations of the centers.

Final

The center has developed a system for the collection of all data and reviewing data on an ongoing basis and at the end of each fiscal year. The center meets on a quarterly basis to review any PREA incidents. This report is submitted to DOC for review.

Standard 115.289 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 center stores all incident reports in the compliance officer's office. The center policy requires all incident reports be kept in locked areas. The center requires all electronic data be stored on encrypted file folders and has a policy on computer safety.

Policy, Materials, Interviews and Other Evidence Reviewed

☒ Completed Pre-Audit Questionnaire
☒ Interview with Executive Director
☒ Interview with Compliance Officer

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.

Robert Manville 1/27/2017

Auditor Signature Date