Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Interim Audit Report: Click or tap here to enter text. ☒ **N/A**
If no Interim Audit Report, select N/A
Date of Final Audit Report: November 23,2021

Auditor Information

Name: Farooq Mallick	**Email:** afarooq.mallick@gmail.com
Company Name: PREA Juvenile Auditors of America, LLC	
Mailing Address: 79 Jansen Road	**City, State, Zip:** New Paltz, NY 12561
Telephone: 845-594-8161	**Date of Facility Visit:** October 24-25, 2021

Agency Information

Name of Agency: Lutheran Social Services of South Dakota			
Governing Authority or Parent Agency *(If Applicable):* N/A			
Address: 705 E. 141st Street		**City, State, Zip:** Rapid City, SD 57701	
Mailing Address: 705 E. 141st Street		**City, State, Zip:** Rapid City, SD 57701	
The Agency Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal
Agency Website with PREA Information: www.lsssd.org			

Agency Chief Executive Officer

Name: Betty Oldenkamp	
Email: Betty.Oldenkamp@LssSD.org	**Telephone:** 605-444-7500

Agency-Wide PREA Coordinator

Name: Staci Jonson	
Email: Staci.Jonson@LssSD.org	**Telephone:** 605-444-7500
PREA Coordinator Reports to:	**Number of Compliance Managers who report to the PREA Coordinator:** 5

Amy Witt, Vice President, Children & Youth Services	

Facility Information

Name of Facility: Arise Youth Center – West (AYCW)			
Physical Address: 3505 Cambell Street		**City, State, Zip:** Rapid City, South Dakota 57701	
Mailing Address: 3505 Cambell Street		**City, State, Zip:** Rapid City, South Dakota 57701	
The Facility Is:	☐ Military	☐ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal

Facility Website with PREA Information: www.lsssd.org

Has the facility been accredited within the past 3 years? ☐ Yes ☒ No

If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years):

☐ ACA

☐ NCCHC

☐ CALEA

☐ Other (please name or describe: Click or tap here to enter text.

☒ N/A

If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe:
NA

Facility Administrator/Superintendent/Director

Name: Mark Kiepke			
Email: Mark.Kiepke@LssSD.org		**Telephone:** 605-716-1837	

Facility PREA Compliance Manager

Name: Mark Kiepke			
Email: Mark.Kiepke@LssSD.org		**Telephone:** 605-716-1837	

Facility Health Service Administrator ☐ N/A

Name: N/A			
Email:		**Telephone:**	

Facility Characteristics

Designated Facility Capacity:	16
Current Population of Facility:	7
Average daily population for the past 12 months:	8
Has the facility been over capacity at any point in the past 12 months?	☐ Yes ☒ No
Which population(s) does the facility hold?	☐ Females ☐ Males ☒ Both Females and Males
Age range of population:	10-17
Average length of stay or time under supervision	9 days
Facility security levels/resident custody levels	Staff Secure

Number of residents admitted to facility during the past 12 months	296
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:	191
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *10 days or more:*	96
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	☐ Yes ☒ No

Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	☐ Federal Bureau of Prisons ☐ U.S. Marshals Service ☐ U.S. Immigration and Customs Enforcement ☐ Bureau of Indian Affairs ☐ U.S. Military branch ☒ State or Territorial correctional agency ☒ County correctional or detention agency ☐ Judicial district correctional or detention facility ☐ City or municipal correctional or detention facility (e.g. police lockup or city jail) ☐ Private corrections or detention provider ☒ Other - please name or describe: Department of Social Services ☐ N/A

Number of staff currently employed by the facility who may have contact with residents:	17
Number of staff hired by the facility during the past 12 months who may have contact with residents:	22
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	0
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0

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

Medical and Mental Health Services and Forensic Medical Exams	
Are medical services provided on-site?	☒ Yes ☐ No
Are mental health services provided on-site?	☒ Yes ☐ No

Where are sexual assault forensic medical exams provided? Select all that apply.	☐ On-site ☒ Local hospital/clinic ☐ Rape Crisis Center ☐ Other (please name or describe: Click or tap here to enter text.)

Investigations

Criminal Investigations

Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:	0
When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.	☐ Facility investigators ☐ Agency investigators ☒ An external investigative entity
Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)	☒ Local police department ☒ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☐ Other (please name or describe: Click or tap here to enter text.) ☐ N/A

Administrative Investigations

Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	2
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: *Select all that apply*	☒ Facility investigators ☒ Agency investigators ☐ An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	☐ Local police department ☐ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☒ Other (please name or describe: DSS/CPS ☐ N/A

Audit Findings

Audit Narrative (including Audit Methodology)

The auditor's description of the audit methodology should include a detailed description of the following processes during the pre-onsite audit, onsite audit, and post-audit phases: documents and files reviewed, discussions and types of interviews conducted, number of days spent on-site, observations made during the site-review, and a detailed description of any follow-up work conducted during the post-audit phase. The narrative should describe the techniques the auditor used to sample documentation and select interviewees, and the auditor's process for the site review.

This report is for the Arise Youth Center – West in Rapid City, South Dakota. The facility is operated by Lutheran Social Services of South Dakota. It is a private not for profit detention center for male and female adolescents. It was the second Prison Rape Elimination Act (PREA) compliance audit for the facility. Arise Youth Center – West (AYCW) was fist audited during the second year of the second three-year cycle on April 16, 2018 and found to be in compliance on October 25, 2018.

Arise Youth Center – West (AYCW) is a sixteen (16) bed detention facility for male and female adolescents. The on-site portion of the PREA audit began on October 24, 2021 and covered the audit period of October 24, 2020 to October 25, 2021. Prior to arrival the auditor reviewed pertinent agency policies, procedures, and related documentation used to demonstrate compliance with the Department of Justice (DOJ) PREA Standards for Juvenile Facilities.

The Pre-Audit Questionnaire (PAQ) stated that there are seventeen (17) staff at the facility with recurring contact with residents. The facility houses both male and female residents. The average daily population for the last twelve (12) months was eight (8). The facility reported twenty-two (22) allegations of sexual abuse or sexual harassment during the past twelve (12) months. All allegations were administratively investigated by the AYCW investigators. There were no allegations that were criminally investigated. The Pre-Audit Questionnaire states there were no residents who identified as lesbian, gay or bisexual, transgender/intersex residents, limited English proficient residents or any resident who made an allegation of sexual abuse or sexual harassment of a criminal nature during the past twelve (12) months at the facility. This auditor did not receive any correspondence from staff or residents.

The PAQ submitted by the PREA Coordinator included detailed floor plans for the facility. From these floor plans, this auditor was able to determine there are single bedrooms surrounding a staff observation post providing clear lines of sight to rooms. The bathrooms are single user bathrooms with a shower stall and sink. The educational area is located adjacent to the living unit.

Notifications of the on-site portion of the audit were posted throughout the facility and accessible to staff, residents, and visitors on August 22, 2021. Photographs were taken on each housing unit, classrooms, dining area, lobby, and the visiting room. All photos of the notifications emailed to this auditor were date stamped. Emails and phone calls between this auditor and the PREA Coordinator took place on a regular basis in the months leading up to the on-site portion of this audit to review the audit process, schedule, and to request any additional information that was needed to review.

On the morning of October 24, 2021 at approximately 8:00 am, this auditor met with the management team of AYCW to discuss the audit schedule and review any questions or concerns anyone may have about the on-site portion of the audit. The following officials were present:

- Program Director
- PREA Coordinator
- Associate Director

The meeting was followed by a detailed tour of the facility which took approximately one hour. The tour included all areas where residents are permitted. This auditor noticed numerous PREA posters throughout the facility. Posters were printed in both English and Spanish with the telephone numbers to report an allegation.

The facility does not have a medical unit. All services are provided in the community.

The facility has a video surveillance system which consists of twenty (20) cameras of which fifteen (15) are interior and five (5) are exterior. There are no cameras in the bathrooms and there are no cameras that have views of the inside of a resident's room. Average retention time for the system is reported to be thirty (30) days. Recorded images reviewed by this auditor were crisp and fluid.

Following the tour, this auditor met with the management team to review the resident and staff rosters. This auditor then proceeded to interview specialty staff on duty, staff members on shift, and residents at the facility from the rest of the day. Staff members were interviewed from all three shifts.

The second day of the audit was spent interviewing specialty staff members that were present on the 7am-3pm and 3pm-11pm shifts. This auditor interviewed the Facility Director, the Program Directors, PREA Coordinator, Intake staff, Human Resource staff, and the investigator who conducts administrative investigations. After these interviews were completed, this auditor reviewed all current resident files for documentation, verifying PREA education and risk assessments were completed per policy. Access to screening information is limited to intake staff and upper-level administrators. All training records were provided to this auditor to verify that all staff had received PREA training. This was provided by the PREA Coordinator. A Human Resource staff was interviewed and provided staff files to this auditor to verify that all child abuse and criminal backgrounds were performed.

Seven (7) of the seven (7) residents (100% of the population) were interviewed. A total of six (6) boys and one (1) girl were interviewed. This auditor also interviewed a resident who had a cognitive disability and there were no residents who disclosed prior victimization during risk screening. There were no residents who identified as being lesbian, gay or bisexual, transgender, limited English proficient, or any residents who made allegations of sexual abuse (criminal in nature) during the past twelve (12) months at the facility. Ages of the residents ranged from thirteen (13) years to sixteen (16) years old. All of the residents interviewed were familiar with PREA, understood how to report an incident of sexual abuse, sexual assault, or sexual harassment, and were aware of services available to them in the community. Residents stated they felt safe at the facility. All residents stated they received their PREA education upon intake and could articulate multiple ways to report sexual abuse and sexual harassment, the grievance process, calling or writing an outside support organization, third party reporting, and anonymous reporting. All residents stated they were aware of their rights to be free from sexual abuse and sexual harassment. All residents acknowledged being aware when staff members of the opposite gender were outside of their rooms or outside of the bathroom. They all stated that they have privacy when changing clothes, showering and using the toilet. All residents acknowledge being screened upon admission.

The following staff were interviewed:

- Program Director
  - Conducts Unannounced Rounds

- Member of the Sexual Abuse Incident Review Team
- Monitors Retaliation

- Associate Director
  - Conducts Unannounced Rounds
  - Member of the Sexual Abuse Incident Review Team
  - Monitors Retaliation

- PREA Coordinator
  - Member of the Sexual Abuse Incident Review Team

- Intake staff
  - Conducts risk assessments
  - Provides PREA Education

- Human Resource staff

- Investigator
  - Conducts administrative investigations

- Resident Counselors (12)

Randomly selected staff members interviewed had years of experience that ranged from six (6) months to eight (8) years. All of the staff interviewed were knowledgeable of PREA, PREA Policy and Procedures regarding the zero-tolerance policy, and responding to incidents and allegations of sexual abuse, sexual assault and sexual harassment. Staff members stated proper protocols for reporting incidents of imminent sexual abuse and steps to take as a first responder. Staff members interviewed were professional and enthusiastic about their work and PREA knowledge. Staff reported they have been trained to take all suspicions, knowledge, or reports of sexual abuse seriously regardless of how the information has been received. Staff were all aware of their roles and obligations as mandated reporters and how to report allegations of sexual harassment and sexual abuse.

Unannounced rounds are conducted at least twice per month on all shifts, weekends and holidays by upper-level management staff at the facility. Logs of these Unannounced Rounds were reviewed by this auditor and met the standard.

The PREA education program for residents begins upon admission to the facility. Risk assessments are conducted by the Intake staff immediately after the PREA education. All residents are given the PREA Policy, PREA brochures and staff read and explain the basic rules, their safety, their rights, how to report, the grievance process, provides the residents with the hotline number, and what to do if they are sexually abused including being taken to the hospital and offered counseling and support services in the community. Each resident signs and dates an acknowledgement form noting they received the above-mentioned PREA education and the tri-fold pamphlet.

Administrative investigations are conducted by the two (2) AYCW investigators. Any criminal incidents of sexual abuse or sexual harassment are referred to investigators with the Rapid City Police Department or Pennington County Sheriff's Office and Child Protective Services.

Criminal investigations of sexual abuse, assault and harassment are conducted by the Rapid City Police Department or the Pennington County Sheriff's Office. AYCW has a MOU with the Pennington County Sheriff's Office to "abide by all relevant regulations of the Prison Rape Elimination Act (PREA). It also has a MOU with Monument Health for SAFE/SANE forensic medical examinations. The agency has a current MOU with Working Against Violence, Inc., to make available to the victim, a victim advocate. This advocate will accompany and support the victim through the forensic medical examination process and investigatory interviews. The advocate will also provide emotional support, crisis intervention, information, and referrals to the victim. The facility reported twenty-two (22) allegations of sexual harassment during this audit period. All allegations were administratively investigated and none were criminally investigated. There were no PREA Sexual Abuse Incident Review Forms at AYCW during the past twelve (12) months. This auditor was provided a template of the PREA Sexual Abuse Incident Review Form and the Facility Director and the PREA Coordinator were able to describe the process in detail during their interviews.

AYCW has developed thorough and detailed policies that address all of the PREA standards related to Prevention Planning, Response Planning, Training and Education, Screening for Risk of Social Victimization and Abusiveness, Official Response Following Juvenile Report, Investigations, Discipline, Medical and Mental Health Care, and Data Collection.

This auditor conducted an exit meeting with AYCW management team following the on-site portion of the audit October 25, 2021. During the exit meeting, this auditor shared the preliminary findings of the audit and thanked the team for their dedication and commitment to the full implementation of PREA in their facility.

Facility Characteristics

The auditor's description of the audited facility should include details about the facility type, demographics and size of the inmate, resident or detainee population, numbers and type of staff positions, configuration and layout of the facility, numbers of housing units, description of housing units including any special housing units, a description of programs and services, including food service and recreation. The auditor should describe how these details are relevant to PREA implementation and compliance.

Arise Youth Center – West is located in Rapid City South Dakota. This facility is under the oversite of Lutheran Social Services of South Dakota. Arise Youth Center – West is a staff secure facility consisting of one stand-alone building containing one living unit designed for sixteen (16) residents. This single building encompasses all resident programming, recreation, education and sleeping units. The sixteen (16) single bed living units surround a staff observation post providing clear lines of sight to rooms, restroom/shower rooms and program space. The education area is located adjacent to the living units, restrooms and shower rooms. The population is coed and made up of ten to seventeen-year-old residents with an average length of stay just over ten (10) days. The facility population at the time of audit was seven (7) residents.

The facility maintains no on-site medical or mental health services. In emergency situations facility staff may (if available) utilize the medical staff at the Pennington County Juvenile Services Center in the adjacent facility. Otherwise, the facility utilizes Monument Health Rapid City Hospital located 2 miles from the facility. Forensic medical exams. Mental Health Services are provided by Lutheran Social Services staff that are not located full time in this facility.

Arise Youth Center – West does maintain two designated trained administrative investigators. Any criminal incidents of sexual abuse or sexual harassment are referred to investigators with the Rapid City Police Department or Pennington County Sheriff's Office and Child Protective Services.

Summary of Audit Findings

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

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

Standards Exceeded

Number of Standards Exceeded: 1
List of Standards Exceeded: 115.322

Standards Met

Number of Standards Met: 42

Standards Not Met

Number of Standards Not Met: 0
List of Standards Not Met: NA

AYCW has implemented a Zero Tolerance of Sexual Abuse Policy 2.1. This policy comprehensively addresses this facility's approach to preventing, detecting, and responding to all forms of sexual abuse and sexual harassment. This policy contains necessary definitions, sanctions, and descriptions of the facility's strategies and responses to sexual abuse and sexual harassment; and forms the foundation for the facility's training efforts with residents, staff, volunteers, and contractors.

The agency has a designated PREA Coordinator who reports directly to the Vice President, Children & Youth Services. All staff members and residents interviewed demonstrated they not only received but understood the education and training that was offered to them. Staff receive annual PREA training and residents are educated upon admission.

AYCW has a Memorandum of Understanding (MOU) with Monument Health for SAFE/SANE forensic medical examinations. This auditor spoke to a representative from Monument Health to confirm the process stated in the MOU. The agency has an MOU with Working Against Violence, Inc., to make available to the victim, a victim advocate. This auditor spoke to a representative from the Working Against Violence, Inc. to confirm the process stated in the MOU.

All administrative investigations were completed by the AYWC investigators and some will be investigated by the Department of Social Services. There have been twenty-two (22) allegations of sexual abuse, assault, or harassment during the past twelve (12) months. If the allegation is criminal in nature, it would be investigated by the Rapid City Police Department or the Pennington County Sheriff's Office. There were no PREA Sexual Abuse Incident Reviews at AYWC during the past twelve (12) months. There were twenty-two (22) allegations of sexual harassment that were administratively investigated and sixteen (16) were substantiated, one (1) unsubstantiated, one (1) unfounded, and four (4) did not meet the criteria. This auditor was provided with a template of the PREA Sexual Abuse Incident Review form; and the PREA Coordinator and the Program Director were able to describe the process in detail during their interviews.

All residents admitted to the facility receive timely PREA education at intake. Intake staff complete all PREA educational during the intake process. They also conduct the screening for Risk of Sexual Victimization and Abusiveness immediately after the PREA education. Any pertinent information is recorded and communicated to staff members for room assignment or additional supervision to ensure the safety and security of the resident and all of the residents in the facility.

All employees at AYWC receive the most current PREA practices and policies. Staff also receive formal refresher training every two (2) years with supplemental refresher information provided in-between years. The training includes eleven (11) different topics required by the PREA standards:

1. Agency Zero-Tolerance Policy.
2. Fulfilling their responsibilities under agency's sexual misconduct, prevention, detection, reporting, and response policies and procedures.
3. Residents' right to be free from sexual abuse, assault, and harassment.
4. Right of the residents and employees to be free from retaliation.
5. Dynamics of sexual misconduct in juvenile facilities.
6. Common reactions of juvenile victims of sexual abuse and sexual harassment.
7. How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual and sexual abuse between residents.
8. How to avoid inappropriate relationships with residents.
9. Effective and professional communication with the residents, including those who identify as lesbian, gay, bi-sexual, transgender and questioning (LGBTQ), or gender non-conforming.
10. Compliance with relevant laws related to mandatory reporting of sexual abuse.
11. Laws governing consent for AYCW youth.

All volunteers and contractors who may have contact with residents have been trained on their responsibilities, the agency zero-tolerance policy regarding sexual abuse and sexual harassment, and how to report such allegations. Prior to entering the facility, all volunteers and contractors are given the agency zero tolerance policy and given PREA training and Acknowledgement Form to review and sign off on noting they understood the material.

During the on-site portion of the audit, it was noted that posters are posted throughout the facility to educate both staff and residents on the agency PREA policies. Brochures noting PREA requirements and hotline numbers are given to all residents, staff, volunteers, contractors, and visitors. The agency also has PREA information for both residents and the public posted on its website.

PREVENTION PLANNING

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

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

115.311 (a)

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

115.311 (b)

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

115.311 (c)

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

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

The agency has developed a stand-alone PREA Policy mandating zero tolerance towards all forms of sexual abuse and sexual harassment. It comprehensively addresses the facility's approach to preventing, detecting, and responding to all forms of sexual abuse and sexual harassment. This policy contains the necessary definitions, procedures, and the facility's strategies and responses to sexual

abuse and sexual harassment. This policy also outlines the facility's training and education of its residents, staff, volunteers, and contractors. The youth receive detailed information about their rights, grievances, and reporting within 24 hours of their admission. The facility's organizational charts clearly depict the roles of the PREA Coordinator. Interviews with the PREA Coordinator proved their knowledge of the PREA standards and their commitment to the implementation of the PREA standards. Notice of the PREA compliance audit was posted on all living units and other prominent locations throughout the facility.

During interview with the PREA Coordinator, she stated that she has the authority to develop, implement and oversee the agency's effort to comply with the PREA standards. She also expressed that she has sufficient time to accomplish these duties.

The following information was utilized to verify compliance with this standard:

- LSS PREA Policy
- Agency and Facility Organizational Chart
- Pre-audit Questionnaire

Interviews:

- Interview with Program Director
- Interview with Agency PREA Coordinator

Standard 115.312: Contracting with other entities for the confinement of residents

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

115.312 (a)

- If this agency is public and it contracts for the confinement of its residents with private agencies or other entities including other government agencies, has the agency included the entity's obligation to adopt and comply with the PREA standards in any new contract or contract renewal signed on or after August 20, 2012? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☐ Yes ☐ No ☒ NA

115.312 (b)

- Does any new contract or contract renewal signed on or after August 20, 2012 provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards? (N/A if the agency does not contract with private agencies or other entities for the confinement of residents.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

Arise Youth Center -West (AYCW) does not contract for the confinement of its residents with other private agencies/entities. This was confirmed during an interview with the Program Director.

Reviewed documentation to determine compliance:

- Pre-Audit Questionnaire

Interviews:

- Interview with Program Director
- Interview with Agency PREA Coordinator

Standard 115.313: Supervision and monitoring

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

115.313 (a)

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

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

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

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

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

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

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

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

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

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

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

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

115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? ☒ Yes ☐ No

- In circumstances where the staffing plan is not complied with, does the facility document all deviations from the plan? (N/A if no deviations from staffing plan.) ☐ Yes ☐ No ☒ NA

115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.)
  ☒ Yes ☐ No ☐ NA

- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) ☒ Yes ☐ No ☐ NA

- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) ☒ Yes ☐ No ☐ NA

- Does the facility ensure only security staff are included when calculating these ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) ☒ Yes ☐ No ☐ NA

- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? ☒ Yes ☐ No

115.313 (d)

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

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility’s deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No

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

115.313 (e)

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS Policy requires the facility to develop, implement and document a plan that provides for adequate levels of staffing, and where applicable video monitoring to protect youth against sexual abuse. The Staffing Plan must be completed and submitted to the Agency PREA Coordinator. In determining adequate staffing levels and the need for video monitoring, facilities must take into consideration:

1. Generally accepted juvenile detention and correctional/secure residential practices
2. Any judicial findings of inadequacy
3. Any findings of inadequacy from federal investigative agencies
4. Any findings of inadequacy from internal or external oversight bodies
5. All components of the facility's physical plant (including "blind spots" and/or areas where staff or youth may be isolated)
6. Composition of the different populations within its facilities
7. Number and placements of supervisory staff
8. Programs occurring on each shift
9. Relevant laws, regulations and standards
10. Prevalence of substantiated and unsubstantiated incidents of sexual abuse
11. Minimum staff to youth ratios must be 1 to 8 during waking hour and 1 to 16 during sleeping hours.

Any deviations form the plan due to limited and discrete exigent circumstances must be documented on the Video Surveillance and Staff Plan. Only security staff must be included in those reports.

There were seven (7) residents residing at AYCW during the on-site portion of this audit. The average daily population at the facility during the past twelve (12) months has been eight (8) residents.

The annual Video Surveillance and Staffing Plan at AYCW also addresses the facility staffing plan and requirements. The plan is reviewed on an annual basis and was reviewed by the Program Director on October 6, 2021.

The facility is equipped with twenty (20) video surveillance cameras (15 interior and 5 exterior cameras). Recording from these devices remain on a secure server for approximately thirty (30) days. Videos from all major incidents are reviewed by the Program Director. It was noted during the interviews with the Program Director that random video surveillance is also reviewed on a regular basis.

The Program Director reported that there have been no deviations from the staffing plan during the past twelve (12) months. He also reported that in the event management staff feel staffing ratios cannot be maintained during the upcoming shift, staff would be held over and paid overtime to meet the ratios. Interviews with the Program Director and PREA Coordinator revealed that staffing is monitored shift to shift and that adjustments are made as needed to ensure the ratios are met. Staff schedules and resident rosters were also reviewed by this auditor to confirm compliance.

LSS PREA Policy page 25 (C) states, “whenever necessary, but no less frequently than once each year, for each facility the agency operates, in consultation with the PREA Coordinator required by 115.311, the agency shall assess, determine, and document whether adjustments are needed to:

1. The Staffing Plan;
2. Prevailing staffing patterns;
3. The facility’s deployment of video monitoring systems and other monitoring technologies.”

A review of Staff Plan confirmed this plan was reviewed on an annual basis and was reviewed by the Program Director on October 6, 2021.

Unannounced Rounds are conducted by upper-level management staff. Unannounced Rounds are conducted on all three (3) shifts, at night, on weekends, and on holidays. The facility maintains a log of all conducted rounds with the date, time, facility activities and what staff were on duty. The Program Director or designee conduct these rounds. This auditor was able to review the Unannounced Rounds Logs for verification that these rounds are occurring.

Facility Program Director was able to discuss how he completes the unannounced rounds during his interview, assures minimum ratios are being met and his inspection of all areas including the housing unit. He also stated that he conducts random rounds by selecting different times of the day/night and days of the week.

Review of documentation and proof to determine compliance:

- LSS PREA Policy
- Staffing Schedules
- Resident Roster
- Video Surveillance and Staff Plan

- Unannounced Rounds Logs
- Location of Video Surveillance Cameras (interior and exterior)
- Tour of the Facility

Interviews:

- Interview with Program Director
- Interview with PREA Coordinator
- Interview with random staff from all three (3) shifts
- Interview with random youth

Standard 115.315: Limits to cross-gender viewing and searches

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

115.315 (a)

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

115.315 (b)

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

115.315 (c)

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

115.315 (d)

- Does the facility have policies that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No

- Does the facility have procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No

- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? ☒ Yes ☐ No

- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units) ☒ Yes ☐ No ☐ NA

115.315 (e)

- Does the facility always refrain from searching or physically examining transgender or intersex residents for the sole purpose of determining the resident's genital status? ☒ Yes ☐ No

- If a resident's genital status is unknown, does the facility determine genital status during conversations with the resident, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner? ☒ Yes ☐ No

115.315 (f)

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

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

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does

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

LSS Privacy, Sensitivity and Respect Policy states that any form of pat down, strip search or body cavity search by agency staff is strictly prohibited. The facility does not allow any type of searches where staff are touching residents. Search procedures include removal of socks and shoes by the resident, turning out pockets and waistbands. These types of searches will always require two staff members. A search may also include a wand type of metal detector. If more intrusive searches are deemed necessary, law enforcement would be contacted to perform them. All youth, staff and Program Directors interviewed confirmed that pat searches including cross-gender searches do not occur. All staff have received training regarding the search of a transgender or intersex resident in a respectful and dignified manner though the agency prohibits any physical contact with the residents by staff. There were no transgender or intersex residents in the current population.

The facility is equipped with single restroom and showers so the facility design aids residents to shower, perform bodily functions, and change without non-medical staff of the opposite gender viewing their breasts, buttock, or genitalia. There are no cameras in the bathrooms, showers, youth rooms, or anywhere youth are permitted to change clothes. The facility also has a Privacy, Sensitivity and Respect Policy in place that requires staff to both knock and announce their presence at residents' rooms and bathrooms/shower rooms.

All residents interviewed acknowledged that they have privacy when showering, using the bathroom, and changing clothes. All staff interviewed stated that they both knock and announce their presence at a resident's room and bathroom/shower room. This procedure is practiced per policy.

LSS PREA Policy prohibits staff from entering a resident's bedroom or bathroom/shower room of the opposite gender unless accompanied by a staff member of the same gender as the resident. Policy, Zero Tolerance, also prohibits the searching or physical examining transgender or intersex residents for the sole purpose of determining genital status.

Reviewed documentation to confirm compliance:

- LSS PREA Policy
- LSS Privacy, Sensitivity and Respect Policy
- Staff Training Curriculum
- Staff Training Logs

Interviews:

- Interview with the Program Director
- Interview with the PREA Coordinator
- Interviews with random staff
- Interviews with residents

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

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

115.316 (a)

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who are blind or have low vision? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? ☒ Yes ☐ No

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) ☒ Yes ☐ No

- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

115.316 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? ☒ Yes ☐ No

- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

115.316 (c)

- Does the agency always refrain from relying on resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy states the facility will take appropriate steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse for residents who are limited in their ability to speak or understand English, deaf or hard of hearing, blind or visually impaired, and those with intellectual deficits. The agency has policies regarding Limited English Proficiency (LEP) and Cultural Appreciation that addresses engaging interpreter services and language lines for interpreting purposes.

Lutheran Social Services (LSS) also has the ability to provide video and audio remote services through video conferencing and via phone.

There were no cognitively disabled residents at AYCW during the on-site portion of this audit. Residents interviewed confirmed that all of their needs are met and anytime they do not understand something, they know they can seek assistance from staff members. During interviews with Program Director and PREA Coordinator, they both noted any disabled resident residing at the facility receives an equal opportunity to participate in and benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse.

The agency PREA brochure is available to residents only in English. However, in the event another method is necessary, staff would utilize other means of communication such as engaging interpreter services and language lines to communicate with residents requiring alternative or additional assistance. There were no limited English proficient residents residing at AYCW during the on-site portion of this audit to interview.

Random staff interviews confirmed that residents are not used as interpreters. In addition, it was confirmed during interviews with staff members and the Facility Administration that there have been no circumstances during the past twelve (12) months at AYCW when interpreters, readers, or other types of resident assistance have been used. Staff member interviewed all understood there are interpreters available for the residents.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- PREA Education Program
- Agency PREA Brochure
- PREA Posters

Interviews:

- Interview with Program Director
- Interview with mental health staff
- Interviews with random staff
- Interviews with random residents

Standard 115.317: Hiring and promotion decisions

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

115.317 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

115.317 (b)

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

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

115.317 (c)

- Before hiring new employees, who may have contact with residents, does the agency perform a criminal background records check? ☒ Yes ☐ No

- Before hiring new employees, who may have contact with residents, does the agency consult any child abuse registry maintained by the State or locality in which the employee would work? ☒ Yes ☐ No

- Before hiring new employees who may have contact with residents, does the agency, consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? ☒ Yes ☐ No

115.317 (d)

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

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

115.317 (e)

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

115.317 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? ☒ Yes ☐ No

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? ☒ Yes ☐ No

- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? ☒ Yes ☐ No

115.317 (g)

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

115.317 (h)

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

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does

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

LSS PREA Policy requires the facility to refrain from hiring, promoting, or enlisting the services of any employee, contractor, or volunteer who may have had inappropriate contact with residents, who has engaged, or attempted to engage in any of the prohibited acts described in this standard. Written applications and interview protocols require disclosures of previous arrests or convictions. Enclosed in the Lutheran Social Services (LSS) background check waiver there is a clause stating that staff have a continuing duty to report an adverse contact with law enforcement or sexual misconduct throughout their term of employment. Material omissions regarding misconduct, or the provision of materially false information, are considered to be grounds for termination or withdrawal of an offer of employment, as appropriate. Background investigations are conducted to determine whether the candidate for hire is suitable for employment and includes a criminal background check. Detailed records of these background investigations are maintained in the employee's file. Updated background checks are conducted every five (5) years for those facility staff who may have contact with residents.

Interviews with the Program Director, Human Resource staff, and PREA Coordinator confirmed this process. They also confirmed that volunteers and contractors go through a similar process and are always under supervision when in contact with residents. The agency also provides information on substantiated allegations of sexual abuse or sexual harassment involving a former employee upon receiving a report from an institutional employer for whom such employee has applied to work.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- Review of randomly selected staff files

Interviews:

- Interview with the Program Director
- Interview with the PREA Coordinator
- Interview with Human Resource staff

Standard 115.318: Upgrades to facilities and technologies

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

115.318 (a)

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

115.318 (b)

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

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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AYCW develops a Video Surveillance and Staffing Plan on an annual basis. The 2020-2021 Staffing Plan was signed on October 6, 2021 by the Program Director and was reviewed by this auditor prior to the on-site portion of this audit; and was confirmed during the interview with the Program Director.

There have been no physical plant upgrades or renovations during this audit period. The facility has twenty (20) cameras which are located throughout the facility. Staff maintain good eye sight vision of each other. The auditor observed these procedures during the on-site portion of this audit. The Annual Review of Staffing, Monitoring Technology, clearly addresses the use of technology to improve the safety of youth.

Reviewed documentation to determine compliance:

- 2020-2021 Video Surveillance and Staffing Plan
- Tour of the facility

Interviews:

- Interview with Program Director
- Interview with PREA Coordinator

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

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

115.321 (a)

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

115.321 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

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

115.321 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiary or medically appropriate? ☒ Yes ☐ No

- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No

- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? ☒ Yes ☐ No

- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

115.321 (d)

- Does the agency attempt to make available to the victim a victim advocate from a rape crisis center? ☒ Yes ☐ No

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based

organization, or a qualified agency staff member? (N/A if the agency *always* makes a victim advocate from a rape crisis center available to victims.) ☒ Yes ☐ No ☐ NA

- Has the agency documented its efforts to secure services from rape crisis centers? ☒ Yes ☐ No

115.321 (e)

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

- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? ☒ Yes ☐ No

115.321 (f)

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

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

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

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy states that the agency only performs administrative investigations up to the point that actions appear to be criminal in nature. AYCW staff turn the investigation over to Rapid City Police Department or Pennington County Sheriff's Office and Child Protective Services. AYCW investigators utilize a uniform evidence protocol developed from PREA Juvenile Standards.

The Program Director and the PREA Coordinator stated during their interviews that the facility has a MOU with Monument Health. The MOU states that Monument Health will provide forensic examinations conducted by a SANE/SAFE. In reviewing documentation, there have been no incidents of sexual abuse at AYCW during the past twelve (12) months that involve penetration and required a resident be transported to Monument Health.

The facility has an MOU with Working Against Violence, Inc. to make available to the victim, a victim advocate. This advocate will accompany and support the victim through the forensic medical examination process and investigatory interviews. The advocate will also provide emotional support, crisis intervention, information, and referrals to the victim. A representative from Working Against Violence, Inc. was interviewed by this auditor to confirm that an advocate from the Working Against Violence, Inc. would respond and accompany the victim through the forensic medical examination process and investigatory interviews.

The facility has a MOU with the Pennington County Sheriff's Office to "abide by all relevant regulations of the Prison Rape Elimination Act (PREA)". This auditor spoke to a representative from the Pennington County Sheriff's Office to confirm the MOU is in place.

This auditor interviewed a representative from Monument Health to verify the MOU and confirm that it will provide forensic examination conducted by a SANE/SAFE. This auditor also interviewed an AYCW investigator to confirm that all administrative investigations are conducted by AYCW investigators.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- MOU with Monument Health
- MOU with Working Against Violence, Inc.
- MOU with Pennington County Sheriff's Office

Interviews:

- Interview with Program Director
- Interview with Agency PREA Coordinator
- Interview with AYCW investigator
- Interview with a representative from Monument Health
- Interview with a representative from Working Against Violence, Inc.
- Interview with a representative from Pennington County Sheriff's Office

Standard 115.322: Policies to ensure referrals of allegations for investigations

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

115.322 (a)

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

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

115.322 (b)

- Does the agency have a policy and practice in place to ensure that allegations of sexual abuse or sexual harassment are referred for investigation to an agency with the legal authority to conduct criminal investigations, unless the allegation does not involve potentially criminal behavior? ☒ Yes ☐ No

- Has the agency published such policy on its website or, if it does not have one, made the policy available through other means? ☒ Yes ☐ No

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

115.322 (c)

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

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy states that "Investigations of suspected sexual abuse, rape, and sexual harassment that arises to the level of potential abuse/neglect will be referred to Child Protective Services or law enforcement in alignment with the LSS Incident Reporting policy. LSS will cooperate with investigators and shall endeavor to remain informed on the progress of the investigation. LSS will administratively investigate allegations of sexual harassment of a resident in an LSS facility of those allegations do not fall under the jurisdiction of Child Protective Services or law enforcement. Administrative investigations will be completed as soon as possible but within five days and will include all individuals involved in the allegation. Investigations will be completed for all allegations or reports received including those received anonymously or from a third party".

The facility reported twenty-two (22) allegations of sexual harassment which were investigated by AYCW investigators. All allegations were administratively investigated by the AYCW investigators as sexual harassment allegations. Sixteen (16) were substantiated, one (1) unsubstantiated, and one (1) was unfounded. Four (4) were determined not to meet the criteria.

The agency has added investigative responsibility to its existing website. The website states that the facility will administratively investigate until the point that abuse is discovered. The agency will then refer the investigation to Child Protective Services or law enforcement, both of which have investigative powers.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- MOU with Pennington County Sheriff's Office

Interviews:

- Interview with the Program Director
- Interview with Agency PREA Coordinator
- Interview with AYCW investigator

TRAINING AND EDUCATION

Standard 115.331: Employee training

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

115.331 (a)

- Does the agency train all employees who may have contact with residents on its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on how to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on the right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on the dynamics of sexual abuse and sexual harassment in juvenile facilities? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on the common reactions of juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on how to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on how to avoid inappropriate relationships with residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on how to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No

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

- Does the agency train all employees who may have contact with residents on relevant laws regarding the applicable age of consent? ☒ Yes ☐ No

115.331 (b)

- Is such training tailored to the unique needs and attributes of residents of juvenile facilities? ☒ Yes ☐ No

- Is such training tailored to the gender of the residents at the employee's facility? ☒ Yes ☐ No

- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No

115.331 (c)

- Have all current employees who may have contact with residents received such training? ☒ Yes ☐ No

- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No

- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

115.331 (d)

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

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy meets all aspects of this standard and are incorporated into the training received by all staff. All staff interviewed reported that they received training on all areas noted in this standard. All staff interviewed were aware of their obligations related to the PREA policies, their obligations as mandated reporters of abuse, their duties as first responders, and the facility protocols related to evidence collection. Electronic documentation was verified on the agency's on-line training system. Hard copies are maintained in the staff member's personnel file. Contracted employees and volunteers complete the training. The training curriculum utilized by the facility meet all aspects of this standard as follows:

1. The agency's policy on zero tolerance for sexual abuse and sexual harassment.
2. How to fulfill their responsibilities under agency sexual misconduct prevention, detecting, reporting, and response policy and procedures.
3. Residents' right to be free from sexual abuse and sexual harassment.

4. The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment in juvenile facilities.
5. Dynamics of sexual abuse and sexual harassment in confinement.
6. Common reactions of sexual abuse and sexual harassment juvenile victims.
7. How to detect and respond to signs of threatened and actual sexual misconduct.
8. How to avoid inappropriate relationships with residents.
9. How to communicate effectively and professionally with residents, including those who identify as lesbian, gay, transgender, intersex, or gender non-conforming.
10. How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.
11. Relevant laws regarding the applicable age of consent.

During the on-site portion of this audit, it was noted that posters were posted throughout the facility to educate both the staff and residents on PREA policies. Brochures noting PREA requirements are given to residents, staff, volunteers, and contractors.

The Pre-Audit Questionnaire documented that all staff currently employed were trained and retrained on the PREA requirements during the past year. Interviews with staff members also confirmed they received the training and understood the material that was covered in the training they received. This auditor was able to confirm the staff training records on the agency's on-line training system.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- PREA Training Curriculum
- Mandated Reporter Curriculum
- Random employee files

Interviews:

- Interview with Program Director
- Interviews with random staff

Standard 115.332: Volunteer and contractor training

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

115.332 (a)

- Has the agency ensured that all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's sexual abuse and sexual harassment prevention, detection, and response policies and procedures? ☒ Yes ☐ No

115.332 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and

contractors shall be based on the services they provide and level of contact they have with residents)? ☒ Yes ☐ No

115.332 (c)

- Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy states that "LSS shall train all contractors and volunteers on the most current PREA practices and policies".

All volunteers and contractors receive training using the agency PREA brochure and are required to sign off on their understanding of the training they receive. This training must be completed prior to the contractor or volunteer having interaction with youth in the facility. The agency/facility maintains documentation regarding volunteer and contractor training. This auditor was provided with the acknowledgment forms. Interview with the Program Director confirmed this practice. There were no volunteers or contractors available for interview.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- PREA Brochure for Contractors and Volunteers
- Signed Training Acknowledgement of a Volunteer
- Signed Training Acknowledgement of a Contactor

Interviews:

- Interview with Program Director

Standard 115.333: Resident education

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

115.333 (a)

- During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No

- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Is this information presented in an age-appropriate fashion? ☒ Yes ☐ No

115.333 (b)

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

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

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.333 (c)

- Have all residents received the comprehensive education referenced in 115.333(b)?
  ☒ Yes ☐ No

- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility?
  ☒ Yes ☐ No

115.333 (d)

- Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are deaf? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills? ☒ Yes ☐ No

115.333 (e)

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

115.333 (f)

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

Auditor Overall Compliance Determination

☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy regarding sexual abuse and sexual harassment is explained to each resident during the intake process. Residents also receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment including contact numbers for Child Protective Services and the South Dakota Advocacy Services. This information is presented in an age-appropriate manner. During intake, residents receive a more comprehensive education than standard PREA intakes. Standards call for this comprehensive training to take place within ten (10) days. AYCW provides this training during intake due to the fact that the average length of stay is ten (10) days. This way staff ensure residents receive this education while at the facility.

The policy states that all education and information shall be provided in formats accessible to all youth including those who have limited English proficiency, are deaf, visually impaired, or otherwise disabled, as well as youth who have limited reading skills. AYCW documents in the resident's file their participation in such intake educational sessions.

All residents interviewed confirmed they received comprehensive PREA education during their intake. They acknowledge receiving the PREA brochure. This auditor reviewed seven (7) resident files during the on-site portion of this audit and all seven (7) files reviewed contained documentation noting the resident received the PREA education at intake.

Interview with intake staff confirmed all PREA education information is communicated orally, in writing, and in a language clearly understood by the resident during the intake process. Language assistance resources are available through interpreter services. The facility also ensures that key information about PREA is continuously and readily available or visible through posters and PREA brochures.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- Youth Education Program Curriculum
- Youth PREA Acknowledgement Form
- PREA Posters
- Resident files
- Tour of the facility

Interviews:

- Interview with Agency PREA Coordinator
- Interview with Intake Staff
- Random resident interviews

Standard 115.334: Specialized training: Investigations

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

115.334 (a)

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

115.334 (b)

- Does this specialized training include techniques for interviewing juvenile sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

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

- Does this specialized training include sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☒ Yes ☐ No ☐ NA

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

115.334 (c)

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

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy states that AYCW investigators only conduct administrative investigations. The AYCW investigators have completed a variety of trainings regarding investigations as well as specific trainings related to interviews and interrogations of juveniles in institutional settings. The training was received through the South Dakota Department of Corrections using the National Institute of Corrections curriculum. Interviews with AYCW investigator confirmed the training they received and that they do not conduct criminal investigations.

It should be noted that staff trained investigators at this facility only investigate cases of alleged sexual abuse or harassment to the point that it appears to be criminal in nature. At that time, staff investigators contact law enforcement and Child Protective Services to continue with a criminal investigation.

There have been twenty-two (22) cases of allegations that have been administratively investigated by the AYCW investigators. There have been no criminal investigations conducted by the Pennington County Sheriff's Office.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- Investigators Training Curriculum
- MOU with Pennington County Sheriff's Office

Interviews:

- Interview with Program Director
- Interview with Agency PREA Coordinator
- Interview with representative from Pennington County Sheriff's Office
- Interview with AYCW investigator

Standard 115.335: Specialized training: Medical and mental health care

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

115.335 (a)

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

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

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

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

115.335 (b)

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

115.335 (c)

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

115.335 (d)

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

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

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy states that LSS shall ensure that the all full and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in:

- How to detect signs of sexual abuse and sexual harassment
- How to preserve physical evidence of sexual abuse
- How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and
- How to and whom to report allegations or suspicions of sexual abuse and sexual harassment

Medical staff do not conduct forensic examinations. In the event of an allegation of sexual abuse with penetration, forensic examinations are conducted at Monument Health by a SAFE/SANE. A MOU is in place with Monument Health that confirms a SAFE/SANE completes forensic examinations. This auditor was able to interview a representative from Monument Health who confirmed forensic examinations are conducted by a SAFE/SANE in the event of an incident of sexual abuse. There have been no cases that required a forensic examination during the past twelve (12) months.

This auditor received and reviewed medical and mental heath staff training records, training certificates and sign-off acknowledgment forms. In addition, interviews with medical and mental health staff confirmed they had received and understood the specialized trainings they received specific to their job titles. All medical and mental health staff also received all mandated training including Mandated Reporter Training and PREA training.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- MOU with Monument Health
- Employee Training Curricula
- Employee Training Logs

Interviews:

- Interview with medical nurse
- Interview with mental health staff
- Phone interview with representative from Monument Health

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

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

115.341 (a)

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

- Does the agency also obtain this information periodically throughout a resident's confinement? ☒ Yes ☐ No

115.341 (b)

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

115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (1) Prior sexual victimization or abusiveness? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (3) Current charges and offense history? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (4) Age? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (5) Level of emotional and cognitive development? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (6) Physical size and stature? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (7) Mental illness or mental disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (8) Intellectual or developmental disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (9) Physical disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (10) the residents' own perception of vulnerability? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? ☒ Yes ☐ No

115.341 (d)

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

115.341 (e)

- Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy addresses the standards related to screening residents for Risk of Sexual Victimization and Abusiveness. The PREA intake assessment instrument will be administered within seventy-two (72) hours of the resident's arrival at the facility. The PREA instrument will be used periodically during every resident's stay at the facility as indicated to reassess the resident's risk level; and is used to ascertain information about:

1. Prior victimization or abusiveness
2. Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender or intersex, and whether the resident may therefore be vulnerable to sexual abuse
3. Current charges and offense history
4. Age
5. Level of emotional and cognitive development
6. Physical size and stature
7. Mental illness or mental disabilities
8. Intellectual or developmental disabilities
9. Physical disabilities
10. The resident's own perception of vulnerability
11. Any other specific information about individual residents that may indicate heightened need for supervision additional safety precautions, or separation from certain other residents

During the past twelve (12) months there have been one hundred and ninety-one (191) residents admitted whose length of stay in the facility was for seventy-two (72) hours or more. All residents admitted into the facility were screened for risk of sexual victimization or risk of sexually abusing other residents within seventy-two (72) hours of being admitted to the facility. This auditor was able to confirm the Vulnerability Assessment is completed upon intake immediately after the PREA education. Intake staff who complete the Vulnerability Assessment, who were interviewed, understood how to administer this screening and were

aware of its importance in keeping residents safe from sexual abuse. This auditor was able to review the Vulnerability Assessment that is used to screen residents and confirmed this form captures the information required for this standard.

All completed assessments are securely maintained in electronic files that are password protected, thus specifically controlling the dissemination of screening results. All pertinent necessary information is recorded and communicated to staff members for room assignments or additional supervision purposes only to ensure sensitive information is not exploited to the resident's detriment by staff or other residents.

Interviews residents confirmed the screening assessment has been completed as noted in the above-mentioned policies, as well as the residents stated they were asked questions when they first arrived as to whether they had ever been sexually abused, if they had any disabilities, or if they were fearful of sexual abuse at the facility. Seven (7) resident files were reviewed for documentation verifying the risk of assessments being completed within seventy-two (72) hours of admission.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- Vulnerability Assessment Instrument: PREA Assessment
- Completed Vulnerability Assessments for seven (7) residents
- Review of residents' electronic files

Interviews:

- Interview with Agency PREA Coordinator
- Interview with intake staff who complete the Vulnerability Assessment
- Interviews with residents

Standard 115.342: Use of screening information

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

115.342 (a)

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Housing Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Bed assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Work Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Education Assignments? ☒ Yes ☐ No

- Does the agency use all of the information obtained pursuant to § 115.341 and subsequently, with the goal of keeping all residents safe and free from sexual abuse, to make: Program Assignments? ☒ Yes ☐ No

115.342 (b)

- Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

- Do residents in isolation receive daily visits from a medical or mental health care clinician? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

- Do residents in isolation also have access to other programs and work opportunities to the extent possible? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

115.342 (c)

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

- Does the agency always refrain from placing transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

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

115.342 (d)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider, on a case-by-case basis, whether a placement

would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? ☒ Yes ☐ No

- When making housing or other program assignments for transgender or intersex residents, does the agency consider, on a case-by-case basis, whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems? ☒ Yes ☐ No

115.342 (e)

- Are placement and programming assignments for each transgender or intersex resident reassessed at least twice each year to review any threats to safety experienced by the resident? ☒ Yes ☐ No

115.342 (f)

- Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when making facility and housing placement decisions and programming assignments? ☒ Yes ☐ No

115.342 (g)

- Are transgender and intersex residents given the opportunity to shower separately from other residents? ☒ Yes ☐ No

115.342 (h)

- If a resident is isolated pursuant to provision (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

- If a resident is isolated pursuant to provision (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

115.342 (i)

- In the case of each resident who is isolated as a last resort when less restrictive measures are inadequate to keep them and other residents safe, does the facility afford a review to determine whether there is a continuing need for separation from the general population EVERY 30 DAYS? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy states that the facility uses all information gained through intake and screening to make housing, bed, program, and educational assignments with the goal of keeping all residents safe and free from sexual abuse. With limited housing options, those residents requiring more observations are placed in rooms closer to the staff observation posts. All resident rooms are single occupancy rooms.

Lutheran Social Services (LSS) has a stand-alone LGBTI Policy. It states that room assignment will be based on the risks determined by the intake screen, as well as information ascertained through conversations during the intake process with the goal of keeping all youth safe and free from sexual abuse.

a. Youth shall not be placed in particular housing based on identification alone or status.
b. All housing, bed placements will be made with the sole intention of ensuring the youth's health and safety.
c. Standard 115.342(e) calls for placement and program assignments for transgender or intersex resident's to be reassessed at least twice each year. The average length of stay at AYCW is ten (10) days so this standard does not apply to this facility. Residents can be reassessed at any time based on any additional information received that would indicate a reassessment may be needed.
d. Transgender or Intersex residents own views in respect to his or her safety is given serious consideration. All residents including transgender and intersex residents are given the opportunity to shower separately from other residents. This facility is designed with single occupancy restrooms and showers.

Although isolation is rare at AYCW, it calls for all to document the circumstances and requires the Associate Directors and Program Directors to review the documentation. Policy and procedures also outline that those residents separated for their safety are provided the same access to programming, visits, educational, vocational, recreational, medical, and mental health services offered to other residents.

There were no youth in the facility during the audit that identified themselves as LGBTI. Of the none youth files this auditor reviewed, none of the residents were identified as sexually vulnerable form the Vulnerability Assessment Instrument.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- LSS LGBTI Policy
- Vulnerability Assessment of seven (7) residents
- Housing Log

Interviews:

- Interview with Program Director
- Interview with Agency PREA Coordinator
- Interview with Intake Staff
- Interviews with residents

REPORTING

Standard 115.351: Resident reporting

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

115.351 (a)

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

115.351 (b)

- Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private entity or office that is not part of the agency? ☒ Yes ☐ No
- Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials? ☒ Yes ☐ No
- Does that private entity or office allow the resident to remain anonymous upon request? ☒ Yes ☐ No
- Are residents detained solely for civil immigration purposes provided information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security to report sexual abuse or harassment? (N/A if the facility *never* houses residents detained solely for civil immigration purposes.) ☐ Yes ☐ No ☒ NA

115.351 (c)

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

- Do staff members promptly document any verbal reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

115.351 (d)

- Does the facility provide residents with access to tools necessary to make a written report? ☒ Yes ☐ No

- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy provides multiple ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violations of responsibilities that may have contributed to such incidents. These are:

- Verbally to any employee
- In writing through a grievance form using the Youth Grievance Process
- Resident may contact an outside entity in the form of Child Protective Services, South Dakota Advocacy Services and Working Against Violence, Inc. The resident may remain anonymous when reporting to outside entities
- Parents

All youth interviewed confirmed they have received information instructing them on how to report allegations of sexual abuse, sexual harassment, or retaliation. Resident information is delivered to the residents through the intake process, PREA education, PREA brochures and posters. Numerous posters were observed throughout the facility by this auditor during the tour. These posters highlighted the various ways residents and staff can report incidents of sexual abuse. Additionally, they reported they understood the grievance process. All knew where to find the Child Protective Services number to report abuse outside the agency. None of the youth interviewed ever reported sexual harassment,

sexual abuse or any form of abuse while at AYCW. All residents receive a PREA brochure at intake regarding how to report abuse and there are posters throughout the facility.

Staff members interviewed were also knowledgeable of the various ways residents and staff can report incidents of sexual abuse, sexual harassment, or retaliation. All staff members interviewed stated they would immediately document a verbal report and process according to the LSS PREA Policy. All staff interviewed were aware of their obligations as mandated reporters.

There were no youth at the facility solely for civil immigration purposes. However, during the interview with the Program Director, it was determined they would provide the resident information on how to contact relevant officials at the Department of Homeland Security to report sexual abuse and/or sexual harassment.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- PREA Brochures
- Posters in facility

Interviews:

- Interview with Program Director
- Interview with Agency PREA Coordinator
- Interviews with randomly selected staff
- Interviews with residents

Standard 115.352: Exhaustion of administrative remedies

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

115.352 (a)

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

115.352 (b)

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

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

115.352 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.)
  ☒ Yes ☐ No ☐ NA

- Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)
  ☒ Yes ☐ No ☐ NA

- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

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

115.352 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.). ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (g)

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

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy complies in full with this standard. There were no incidents of sexual abuse, sexual harassment, or retaliation filed using the grievance process in the past twelve (12) months. No grievances by residents or third parties were filed alleging sexual abuse, harassment or retaliation. Although the policy complies with the standard, a grievance filed that alleges that sexual abuse occurred or alleges an imminent threat would immediately trigger the agency's PREA response procedures. A review of grievance records and interview with the Agency PREA Coordinator confirms that there were no grievances filed related to sexual abuse during this audit period.

All residents interviewed were aware of the grievance procedures. Residents have been informed of the multiple ways they can report an allegation of sexual abuse, assault, or harassment. If a resident filed a grievance regarding sexual abuse, assault, or harassment that report would be handled immediately in the way it is prescribed in the policy.

All staff interviewed were able to describe steps they would take to protect a resident from threated abuse.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- Grievance log
- File of seven (7) residents

Interviews:

- Interview with Program Director
- Interview with Agency PREA Coordinator
- Interviews with randomly selected staff
- Interviews with residents

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

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

115.353 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making assessable mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No

- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? (N/A if the facility *never* has persons detained solely for civil immigration purposes.) ☐ Yes ☐ No ☒ NA

- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.353 (b)

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

115.353 (c)

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

- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☒ Yes ☐ No

115.353 (d)

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

- Does the facility provide residents with reasonable access to parents or legal guardians? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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LSS PREA Policy outline that the facility will provide residents with access to confidential emotional support services. The agency has a MOU with Working Against Violence, Inc. (WAVI) to provide residents with information on and refer victims of rape, sexual assault and sexual molestation to WAVI for crisis intervention and support services as soon as possible. WAVI will provide services such as a Sexual Assault Victim Advocate at AYCW. The victim advocate shall accompany and support the victim through the forensic medical examination process and investigatory interviews, and shall provide confidential emotional support, crisis intervention, information and referrals. The agency also has a MOU with Monument Health. Arise Youth Center – West makes these services available through providing PREA materials, resident handbooks and posters located throughout the facility. The Resident Handbook addresses to the extent communications will be monitored and to the extent to which reports of abuse will be forwarded to the authorities under mandatory reporting laws. The facility also has a policy stating that residents will have access to their attorneys or other legal representation and access to parents or legal guardians.

Interviewed residents were aware of how to access outside agencies through phone numbers provided and posted; and all of them stated they would have access to a telephone if they needed to report anything. All residents interviewed acknowledged ready access to contact with their families (free phone calls) and the ability to contact their lawyer if they so desired. There were no residents who were victims of sexual abuse to interview during the on-site portion of this audit.

All staff interviewed were aware of how residents can access outside agencies through the hotlines.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- MOU with Working Against Violence, Inc.
- MOU with Monument Health
- Resident PREA Intake Brochure
- PREA posters in the facility
- Resident Handbook

Interviews:

- Interview with Program Director
- Interview with Agency PREA Coordinator
- Interviews with randomly selected staff
- Interviews with residents
- Interview with a representative from Working Against Violence, Inc.
- Interview with a representative from Monument Health

Standard 115.354: Third-party reporting

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

115.354 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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LSS PREA Policy describes third-parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist residents in filing grievances relating to allegations of sexual abuse and/or sexual harassment. The third-parties will also be allowed to file grievances on behalf of the residents. Lutheran Social Services (LSS) visitor guide addresses how to report as a third-party. Those options include Program Director, PREA Coordinator, or Child Protective Services.

Interviews with residents confirmed they are aware of who third-parties are. They were also aware that these individuals can report allegations of sexual abuse or sexual harassment on their behalf.

All staff members interviewed acknowledged that they would accept a third-party report of abuse in the same manner as if they had witnessed the abuse themselves.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- LSS website
- PREA Brochure
- PREA posters

Interviews:

- Interviews with randomly selected staff
- Interviews with residents

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

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

115.361 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

115.361 (b)

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

115.361 (c)

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

115.361 (d)

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

- Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

115.361 (e)

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the appropriate office? ☒ Yes ☐ No

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified? ☒ Yes ☐ No

- If an alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? ☒ Yes ☐ No

- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation? ☒ Yes ☐ No

115.361 (f)

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

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy requires all staff to immediately report any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment; retaliation against a juvenile or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation that occurred in the facility, whether or not is part of the LSS. According to the same policy, staff are required to comply with any applicable mandatory child abuse reporting laws.

All staff members interviewed were aware that any knowledge, suspicion, or information regarding an incident of sexual abuse, sexual harassment, staff neglect, or any violation of responsibilities that may have contributed to an incident or retaliation, must be reported to designated supervisors or officials and designated State or local services agencies. Staff are prohibited from revealing any information related to a sexual abuse report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions.

Mental health and medical staff interviewed indicated that disclosure is prohibited to residents regarding limitation of confidentiality and their duty to report any knowledge, suspicion, or information regarding any allegation of sexual abuse or sexual harassment to their direct supervisor immediately upon learning of the allegation. Staff interviews also discussed completing Mandated Reporter training on an annual basis.

All staff members (including medical staff and mental health staff) are trained to treat third-party reports the same as if they witnessed the incident themselves when receiving a report from a third-party.

Interviews with the Program Director, Agency PREA Coordinator, and staff members (including medical staff and mental health staff) confirmed they are aware of how to report an allegation and were aware all administrative investigations are investigated by AYCW investigators and criminal investigations are investigated by the Pennington County Sheriff's Office.

There have been twenty-two (22) allegations of sexual harassment in the past twelve (12) months that have been investigated by the AYCW investigators. There have been no criminal investigations.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- Training Logs
- PREA posters

Interviews:

- Interview with the Program Director
- Interview with the Agency PREA Coordinator
- Interview with nurse
- Interview with mental health staff
- Interview with randomly selected staff

Standard 115.362: Agency protection duties

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

115.362 (a)

- When the agency learns that a resident is subject to a substantial risk of imminent sexual abuse, does it take immediate action to protect the resident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy and the facility's Institutional Plan require an immediate response should a youth be determined to at imminent risk of sexual abuse or assault; it shall take immediate action to protect the youth.

Interview with the Program Director confirmed that the facility would ensure steps are taken to remove the risk to the resident which could include separation from the potential abuser either by transferring the resident to another facility or making an assignment change if the abuser is a staff member. The staff member could also be removed and placed on Administrative Leave pending an investigation. The Program Director also confirmed that staff members would be expected to act immediately to separate the resident at risk from potential abusers. In addition, he reported a Safety Plan would be developed and implemented to ensure the safety of the resident at risk. The Safety Plan would include increased supervision/monitoring, separation from the potential abuser, and making a room change if necessary.

There were no residents that the facility determined was subject to substantial risk of sexual abuse during the past twelve (12) months; where a youth was at substantial risk of imminent sexual abuse. All staff members interviewed were able to articulate what immediate means and what they would do to protect residents should this occur. These included immediately calling for a supervisor to respond to the location; keeping the residents under arms-length supervision until the supervisor arrives; and, if necessary, based on the imminent nature of the threat, securing the resident alone in a room. All staff members stated they would act immediately. If the aggressor was a staff member, interview confirmed that the staff member would be removed or terminated.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- Institutional Plan for Alleged Sexual Abuse

Interviews:

- Interview Program Director
- Interview with Agency PREA Coordinator
- Interviews with randomly selected staff

Standard 115.363: Reporting to other confinement facilities

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

115.363 (a)

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

- Does the head of the facility that received the allegation also notify the appropriate investigative agency? ☒ Yes ☐ No

115.363 (b)

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

115.363 (c)

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

115.363 (d)

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

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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LSS PREA Policy states if the alleged sexual assault/harassment occurred in another youth facility and was reported to be a youth/youth encounter, the Program Director or designee will contact the Program Director or designee of the other facility to report the allegations the next business day. A report will also be made to the local child protection agency to ensure appropriate follow up occurs. All notifications are documented on the LSS Incident Reporting Form. If the alleged sexual assault/harassment occurred in another youth facility and was reported to be a youth/staff encounter, the Program Director or designee will contact the local law enforcement and/or child protection agency and follow the guidance provided from that agency in regards to reporting to the other youth facility. All notifications are documented on the LSS Incident Reporting Form. A written report timeframe is addressed in the agency's Child Abuse and Neglect Policy.

The Program Director or designed will complete follow-up with law enforcement or the child protection agency assigned within thirty (30) days to confirm the allegation is investigated to conclusion.

The facility advised that it did not receive any reports of residents being sexually abused at another confinement facility during the audit period and therefore had no documentation to show this auditor regarding such actions.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- Pre-Audit Questionnaire

Interviews:

- Interview with the Program Director
- Interview with Agency PREA Coordinator

Standard 115.364: Staff first responder duties

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

115.364 (a)

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Separate the alleged victim and abuser? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, if the abuse occurred within a time period that still allows for the collection of physical evidence? ☒ Yes ☐ No

115.364 (b)

- If the first staff responder is not a security staff member, is the responder required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☒ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy states that upon learning of an allegation that a resident was sexually abused, the first staff member to respond shall be required to:

1. Separate the victim and alleged abuser;
2. Preserve and protect the scene until appropriate steps can be taken to collect any evidence;
3. If the abuse occurred within the time period that still allows for the collection of physical evidence, request the alleged victim not take any actions that could destroy physical evidence, including as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, swimming, drinking, or eating;
4. If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged abuser no take any cations that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating;
5. Ensure that any removal of clothes takes place over a clean, fry, white sheet for the preservation of evidence. A separate sheet is to be used for each person;
6. Ensure that all evidence remains dry when possible;
7. Store evidence for each person involved in a separate paper bag, properly labeled with name and date.

All staff interviewed could articulate the steps they would take as a first responder. They also stated that they would immediately report it to the Program Director or designee and document the incident. Their responses were consistent with the LSS PREA Policy.

There were no allegations during the past twelve (12) months, therefore there was no documentation of staff performing these duties.

Reviewed documentation to determine compliance:

- LSS PREA Policy

- Pre-Audit Questionnaire

Interviews:

- Interview with the Program Director
- Interview with the Agency PREA Coordinator
- Interviews with randomly selected staff

Standard 115.365: Coordinated response

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

115.365 (a)

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

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

There have been no incidents in the past twelve (12) months that require the use of the coordinated response. A copy of the facility's Institutional Plan was provided to this auditor. The plan provides clear and concise directions for response to any alleged PREA violation. Interviews with the Program Director, direct care staff, medical staff, and mental health staff indicated that each is knowledgeable of his/her responsibilities in regard to an incident or allegation of sexual assault. All staff were aware of their program's Institutional Plan.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- Facility Institutional Plan

Interviews:

- Interview with Program Director
- Interview with nurse
- Interview with mental health staff
- Interview with randomly selected staff

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

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

115.366 (a)

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

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy states that neither LSS nor any other governmental entity responsible for collective bargaining on the agency's behalf shall enter into or renew any collective bargaining unit agreement that limits the ability to remove alleged staff sexual abusers from contact with any residents pending the outcome of an investigation or a determination of whether and to what extent discipline is warranted. LSS PREA Policy specifically authorizes LSS to protect youth from contact with alleged abusers.

During the interview Program Director stated that any time there is an allegation, a safety plan for the specific resident, and all the residents, is put into place. This always includes removing the staff person from contact with the resident or residents and depending upon the allegation, placing the staff member on Administrative Leave until the investigation is completed.

Reviewed documentation to determine compliance:

- LSS PREA Policy

Interview:

- Interview with Program Director

Standard 115.367: Agency protection against retaliation

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

115.367 (a)

- Has the agency established a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff? ☒ Yes ☐ No

- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

115.367 (b)

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

115.367 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: The conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

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

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Any resident disciplinary reports? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Resident housing changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Resident program changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Negative performance reviews of staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Reassignments of staff? ☒ Yes ☐ No

- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

115.367 (d)

- In the case of residents, does such monitoring also include periodic status checks? ☒ Yes ☐ No

115.367 (e)

- If any other individual who cooperates with an investigation expresses a fear of retaliation, does the agency take appropriate measures to protect that individual against retaliation? ☒ Yes ☐ No

115.367 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy shall protect all residents and staff who report sexual abuse or sexual harassment or cooperate with investigations pertaining to sexual abuse and harassment from retaliation by other staff or residents.

Protective measures may include removal of alleged staff or resident abusers from contact with victims, and emotional support services for residents or staff who fear retaliation for reporting abuse, sexual abuse, and/or sexual harassment or for cooperating with investigations. AYCW has designated a specific staff person charged with monitoring any such retaliation. Monitoring at the facility will continue for at least ninety (90) days following a report of sexual abuse. Items that will be monitored include any resident disciplinary reports, housing or programming changes, negative performance reviews, and reassignments of staff. The facility shall continue such monitoring beyond ninety (90) days if the initial monitoring indicates a continuing need.

There were no reported allegations of sexual abuse or sexual assault thus there were no incidents of retaliation, known or suspected, during the past twelve (12) months. This was confirmed via interview with AYCW investigator.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- Pre-Audit Questionnaire

Interview:

- Interview with Program Director
- Interview with AYCW investigator
- Interview with staff designated to monitor retaliation

Standard 115.368: Post-allegation protective custody

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

115.368 (a)

- Is any and all use of segregated housing to protect a resident who is alleged to have suffered sexual abuse subject to the requirements of § 115.342? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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LSS PREA Policy states LSS does not use isolation to segregate victims unless there is no possible other choice and for as short a duration as necessary. Any use of segregated housing to protect a resident who is alleged to have suffered sexual abuse shall be subject to the requirements of standard 115.342. This will include:

a. LSS will document the basis for the concern to the resident's safety and the reason that no other means of separation can be arranged in an Agency Incident Report.
b. Every twenty-four (24) hours a review will be conducted to ensure there is continued need for separation based on the safety of the resident. *This review must include at least the Associate Director and Program Director, with consultation of the Senior Director and Vice President of Children and Youth Services for extensions beyond twenty-four (24) hours.
c. LSS will ensure that any resident who is separated for their safety is entitled to the same access to programming, visits, educational, vocational, recreational, medical, and mental health services as all other residents within the facility.

The facility did not use segregation or isolation for the purpose of this standard during the audit period. There were no reported instances of sexual abuse during this audit period. Interview with the Program Director confirmed the prohibition of segregated housing for this purpose. During the tour of the facility, this auditor did not notice any places where a resident could be segregated or isolated.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- Tour of the facility

Interview:

- Interview with Program Director

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

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

115.371 (a)

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

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).]
  ☒ Yes ☐ No ☐ NA

115.371 (b)

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

115.371 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses?
  ☒ Yes ☐ No

- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.371 (d)

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

115.371 (e)

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

115.371 (f)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?
  ☒ Yes ☐ No

- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

115.371 (g)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No

- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

115.371 (h)

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

115.371 (i)

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

115.371 (j)

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

115.371 (k)

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

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

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

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy states, investigations of suspected sexual abuse, rape, and sexual harassment that rise to the level of potential abuse/neglect will be referred to Child Protective Services and law enforcement in alignment with the LSS Incident Reporting Policy. LSS will cooperate with investigators and shall endeavor to remain informed on the progress of the investigation. LSS will administratively investigate allegations of sexual harassment of a resident in an LSS facility if those allegations do not fall under the jurisdiction of Child Protective Services or law enforcement. Administrative investigations will be completed as soon as possible but within five (5) days and will include all individuals involved in the allegation.

Investigations will be completed for all allegations or reports received including those received anonymously or from a third party.

In the event of an administrative investigation the following steps will be taken:

a. The staff person who receives the initial report or grievance regarding a potential allegation of abuse will ensure that the resident(s) is currently safe and following all policies and procedures related to evidence and first responder duties;

b. The staff person will report the allegation to the on-duty supervisor as soon as possible assuring compliance with program supervision and ratio requirements;

c. The on-duty supervisor will follow LSS Incident Reporting Matrix regarding additional internal and external notifications;

d. The staff person will complete an agency incident report that includes documentation of physical and testimonial evidence, steps taken to assure resident safety and notifications were made. The incident report will be submitted to the program's PREA investigator;

e. Upon receipt of the incident report, the program's PREA investigator will interview all residents and staff who are involved in the alleged incident using the PREA investigation form. If a resident no longer resides in the facility, the PREA investigator will attempt to interview the youth or document the reason they were unable to complete the interview;

f. LSS refrains from terminating an investigation solely because the source of the allegation recants the allegation;

g. LSS does not require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation;

h. Agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as a resident or staff;

i. Administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse allegation.

All criminal investigations are conducted by Child Protective Services and/or law enforcement. They will make the determination of prosecution referrals.

Interviews with LSS, AYCW investigators confirmed that all staff complete investigations of sexual abuse and sexual harassment receive training through the South Dakota Department of Corrections using the National Institute of Corrections curriculum. The investigator stated that they gather and preserve direct and circumstantial evidence, interview alleged victims, suspected predators, and witnesses during the course of an investigation. In addition, all reports and video footage of the allegation is also reviewed by investigators during an open investigation. The investigator stated that the investigation would continue until a determination is made.

There were no residents who were alleged victims of sexual abuse to review.

This auditor noted the departure of an alleged or abuser or victim from employment or control of the facility/agency does not provide a basis for terminating an investigation. All files are kept as long as the alleged abuser is within LSS custody, if a youth, or employed by the agency, plus five (5) years. This was confirmed with the Agency PREA Coordinator.

There were twenty-two (22) allegations of sexual harassment that were administratively investigated by LSS/AYCW investigators during the past twelve (12) months. There were no allegations of sexual abuse that were investigated by Child Protective Services or by law enforcement. Interviews with the Program Director and LSS/AYCW investigator confirmed this and confirmed the protocols in place for criminal and administrative investigations.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- Pre-Audit Questionnaire
- MOU with Pennington County Sheriff's Office

Interviews:

- Interview with Program Director
- Interview with Agency PREA Coordinator
- Interview with LSS/AYCW investigator

Standard 115.372: Evidentiary standard for administrative investigations

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

115.372 (a)

- Is it true that the agency does not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy states that LSS will not impose a standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. There were twenty-two (22) administrative investigative reports for alleged sexual harassment to confirm the evidentiary standard is being followed.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- Pre-Audit Questionnaire
- Investigative Reports

Interviews:

- Interview with Program Director
- Interview with LSS/AYCW investigator

Standard 115.373: Reporting to residents

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

115.373 (a)

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

115.373 (b)

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

115.373 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No

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

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

115.373 (d)

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

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

115.373 (e)

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

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy states:

a. Following an investigation into a resident's allegation of sexual abuse suffered in the facility, LSS shall inform the resident as to whether the allegation has been determined to be substantiate, unsubstantiated, or unfounded;
b. If LSS did not conduct the investigation, it shall request the relevant information form the investigative agency in order to inform the resident;
c. Following a resident's allegation that a staff member has committed sexual abuse against a resident, LSS shall subsequently inform the resident (unless the agency has determined the allegation is unfounded) whenever:
    1. The staff member is no longer posted within the resident's unit;
    2. The staff member is no longer employed at the facility;
    3. The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility;
    4. The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.
d. Following a resident's allegation that he or she has been sexually abused by another resident, the agency shall subsequently inform the alleged victim whenever:
    1. The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or
    2. The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.
e. All such notifications or attempted notifications shall be documented.

The Program Director and Agency PREA Coordinator stated that the resident would be continually informed as to the ongoing status of the investigation, whether it was youth on youth or staff on youth. All notifications are documented.

The facility had twenty-two (22) allegations of sexual harassment during the past twelve (12) months. All allegations were administratively investigated by LSS/AYCW investigators and sixteen (16) were substantiated, one (1) unsubstantiated, one (1) unfounded, and four (4) did not meet the criteria.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- Pre-Audit Questionnaire

Interview:

- Interview with the Program Director
- Interview with the Agency PREA Coordinator
- Interview with LSS/AYCW investigator

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

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

115.376 (a)

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

115.376 (b)

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

115.376 (c)

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

115.376 (d)

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

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy prohibits staff from engaging in sexual boundary violations, sexual abuse, sexual harassment and retaliation for reporting such conduct. Sexual misconduct perpetrated by staff is contrary to the policies of the facility and professional ethical principles that all employees are about to uphold.

The LSS PREA Policy states:

a. Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. Disciplinary sanctions will be determined based upon the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar disciplinary histories;
b. Termination shall be presumptive disciplinary sanction for staff who have engaged in sexual activity;
c. All terminations for violations of LSS sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

The Pre-Audit Questionnaire indicated that there were no staff that were terminated (or resigned prior to termination) for violating the facility's sexual abuse or sexual harassment policies during the past twelve (12) months. Additionally, there were no staff disciplined for violations of the LSS PREA Policy. This was confirmed during the interview with the Program Director.

Reviewed documentation to determine compliance:

- LSS PREA Policy (Prison Rape Elimination, Information Handouts, and Staff Checklist)

Interview:

- Interview with the Program Director
- Interview with LSS/AYCW investigator

Standard 115.377: Corrective action for contractors and volunteers

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

115.377 (a)

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

115.377 (b)

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

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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LSS PREA Policy states that any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents. In addition, volunteers and contractors will be reported to law enforcement (unless the activity is clearly not criminal) and any relevant licensing body.

Furthermore, policy states remedial measures will be taken in the case of any other violation of the agency's sexual abuse or sexual harassment policies by a volunteer or contractor. This includes consideration of whether further contact with residents will be allowed.

The Pre-Audit Questionnaire indicated that there were no contractors or volunteers reported to law enforcement for engaging in sexual abuse or sexual harassment of residents during the past twelve (12) months.

The Program Director stated that the facility would immediately remove the contractor, or volunteer, from the facility, would contact appropriate authorities, and would not allow them to return until the completion of an investigation. There were no reported instances of sexual assault or sexual harassment by the approved contractors or volunteers during the past twelve (12) months; therefore, there was no documentation to review regarding this standard.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- Pre-Audit Questionnaire
- Signed training acknowledgement of a contractor

Interview:

- Interview with the Program Director
- Interview with the Agency PREA Coordinator

Standard 115.378: Interventions and disciplinary sanctions for residents

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

115.378 (a)

- Following an administrative finding that a resident engaged in resident-on-resident sexual abuse, or following a criminal finding of guilt for resident-on-resident sexual abuse, may residents be subject to disciplinary sanctions only pursuant to a formal disciplinary process? ☒ Yes ☐ No

115.378 (b)

- Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician? ☒ Yes ☐ No

- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.378 (c)

- When determining what types of sanction, if any, should be imposed, does the disciplinary process consider whether a resident's mental disabilities or mental illness contributed to his or her behavior? ☒ Yes ☐ No

115.378 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions? ☒ Yes ☐ No

- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education? ☒ Yes ☐ No

115.378 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

115.378 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No

115.378 (g)

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

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy states that a resident may be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse, resident-on-resident sexual activity, or following a criminal finding of guilt for resident-on-resident sexual abuse. Any resident that violates these policies is subject to disciplinary sanctions commensurate with the nature and circumstances of the incident. Consideration will be taken into the nature and circumstances of the incident, resident history, mental health or disabilities, and precedent of sanctions imposed under similar circumstances. Residents are subjected to disciplinary sanctions for contact with staff if upon investigation it is determined that the staff member did not consent to such contact. Disciplinary action must be administered in a fair, impartial, and expeditious manner. Consideration must also be given to providing the offending resident therapy, counseling, or other interventions for the abuse. JDC as a youth handbook that outlines the behavioral treatment program response for such violations. Based upon the therapeutic nature of these programs, the general tenor of responses is therapeutic in nature.

Interviews with the Program Director and mental health staff confirmed that a resident's mental health is always considered when discipline is imposed for incidents of sexual abuse. In addition, a mental health staff stated the resident's mental health diagnosis is reviewed and considered during Sexual Abuse Incident Reviews following a substantiated or unsubstantiated finding to ensure appropriate discipline was imposed.

Consideration must be given to providing the offending youth therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse. However, the facility may not require participation in such interventions as a condition of access to general programming or education.

Interviews with medical and mental health staff members were conducted by this auditor during the on-site portion of this audit. The interviews confirmed AYCW does offer mental health services for any resident found to have engaged in resident-on-resident sexual abuse. The mental health staff stated the resident's participation in therapy sessions may be required as a condition of access to reward-based incentives, but not as a condition to access to general programming or education.

There were no allegations of resident-on-resident sexual abuse during the past twelve (12) months.

LSS PREA Policy states the facility may only discipline a youth for sexual contact with staff upon a finding that the staff member did not consent to such contact. An interview with the Program Director confirmed a resident would only be disciplined for sexual contact with a staff member upon finding the staff member did not consent to the sexual contact. There were no incidents of resident-on-staff sexual abuse during the past twelve (12) months. The Program Director also confirmed that residents are not disciplined for reports of sexual abuse made in good faith, even if the investigation did not establish evidence sufficient to

substantiate the allegation. The Program Director also noted that any suspicion of possible sexual abuse is reported for investigation.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- Youth Handbook

Interview:

- Interview with Program Director
- Interview with Agency PREA Coordinator
- Interview with mental health staff
- Interview with nurse

MEDICAL AND MENTAL CARE

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

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

115.381 (a)

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

115.381 (b)

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

115.381 (c)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law? ☒ Yes ☐ No

115.381 (d)

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy requires staff performing a youth's intake utilize a standard screening tool to determine if a youth has any immediate and/or emergency medical or mental health needs. If the youth experienced any prior victimization or has perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff shall ensure that the youth will be offered a follow-up meeting with a mental health practitioner or a medical staff within fourteen (14) days of intake. These assessments are documented in clinical notes. Any time an allegation of sexual abuse occurs, the youth will be taken toM onument Health to be seen by a SANE nurse without financial cost to the youth. Upon return from the hospital, the medical staff is to assess for any lingering, acute, or non-acute physical injuries, as well as any psychological impact of the victimization.

There were no residents admitted during the past twelve (12) months who previously perpetrated sexual abuse. Therefore, there was no documentation or files to review. This auditor reviewed randomly selected resident files to confirm there were no residents admitted into the facility who previously perpetrated sexual abuse. This auditor interviewed a mental health practitioner who was able to confirm the referral process whenever it is noted a resident previously perpetrated sexual abuse during the intake screen. The mental health practitioner stated the resident would be referred for an assessment immediately.

During interviews with medical staff, mental health practitioner, and intake staff, it was noted they are mandated reporters and are required by law to report any information they receive from a resident relating to sexual abuse. All staff members interviewed stated they inform the resident upon intake of their reporting duties.

Interviews with the Programs Director and intake staff all indicated they were aware that youth reporting prior sexual victimization or prior sexual aggression are to be referred for a follow-up meeting with medical and mental health staff within fourteen (14) days of intake. They stated that services that are offered include

evaluations, developing a treatment plan, and offering on-going services. Interview with medical staff confirmed that screening includes history of sexual abuse. Per mental health practitioner, youth have access to all medical services available to youth in the community.

All youth interviewed confirmed that they were seen by medical staff shortly after arrival at the facility. A review of _____ youth files noted there were no current youth who have disclosed prior victimization during the screening.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- Vulnerability Assessments
- Log of Admissions
- Files of seven (7) residents

Interviews:

- Interview with Program Director
- Interview with Agency PREA Coordinator
- Interview with the nurse
- Interview with mental health practitioner
- Interview with Intake staff
- Interviews with residents

Standard 115.382: Access to emergency medical and mental health services

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

115.382 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment? ☒ Yes ☐ No

115.382 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362? ☒ Yes ☐ No

- Do staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.382 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☒ Yes ☐ No

115.382 (d)

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

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy states that resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. Arise Youth Center – West has limited medical o mental health staff on duty in the facility. Facility first responders will take preliminary steps to protect the victim and make immediate medical and mental health notifications. Monument Health Rapid City Hospital is utilized for emergency medical and Arise Youth Center -West has an MOU with Monument Health for services.

Facility documentation is maintained through staff incident reports and PREA investigation reports. All medical and mental health secondary records are maintained by off-site medical services and contract service providers.

According to LSS policy resident victims of sexual abuse shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. As stated above all medical secondary records are maintained by off-site medical services ad contract service providers. Treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

AYCW has a MOU with Monument Health to have a forensic examination completed by a SANE/SAFE and provide medical/mental health services at no cost to the victim. This MOU was provided to this auditor for review. In addition, this auditor contacted a representative from Monument Health to confirm resident victims are referred to their facility and receive the services noted in the MOU.

There were no residents at the facility who reported sexual abuse involving penetration during the past twelve (12) months. Therefore, there were no residents sent to Monument Health for a forensic examination.

LSS PREA Policy states, to preserve evidence, an allegation of rape or penetration requires that a resident not be allowed to engage in any activities such as hygiene, washing, showering, brushing teeth, or eating and drinking (unless medically necessary). Residents should also be discouraged from urinating or defecating as that may destroy evidence prior to being presented at the hospital for the gathering of such evidence.

All staff members interviewed confirmed the duties of a first responder and were able to describe their responsibilities if they are a first responder to an allegation of sexual abuse.

This auditor was able to interview a medical staff at the facility who stated any resident of sexual abuse would be offered information and timely access to emergency contraception and sexually transmitted infection prophylaxis while at Monument Health and also follow-up appointments with medical.

LSS PREA Policy states all medical, mental health and counseling services must be provided at no cost to the resident.

This auditor was able to interview the Program Director and a medical staff member during the on-site portion of this audit, and a representative from Monument Health. All interviewed confirmed that any victim of sexual assault would be referred to Monument Health and receive medical and mental health treatment at no cost.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- Facility Institutional Plan
- MOU with Monument Health
- MOU with Working Against Violence, Inc.

Interviews:

- Interview with Program Director
- Interview with Agency PREA Coordinator
- Interview with nurse
- Interview with randomly selected staff
- Interview with representative from Monument Health
- Interview with representative from Working Against Violence, Inc.

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

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

115.383 (a)

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

115.383 (b)

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

115.383 (c)

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

115.383 (d)

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

115.383 (e)

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

115.383 (f)

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

115.383 (g)

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

115.383 (h)

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

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

Per LSS PREA Policy, LSS and its facilities offer medical and mental health evaluations and, as appropriate, treatment to all residents who have been victimized by sexual abuse no matter where the abuse occurred. Evaluations and treatment of such victims include, as appropriate, follow-up services, treatment plans, and when necessary, referrals for continued care following their transfer to or placement in other facilities. These services per policy are consistent with the community level of care.

Policy also calls for resident victims of sexually abusive vaginal penetration while incarcerated be offered pregnancy tests. If pregnancy results from such conduct, victims receive timely and comprehensive information about, and timely access to, all lawful pregnancy-related medical services.

LSS policy states resident victims of sexual abuse while incarcerated be offered tests for sexually transmitted infections as medically appropriate. These treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

The facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within sixty (60) days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners. These evaluations will be determined in collaboration with the resident's placing agency/legal guardian.

An interview with the Program Director confirmed any resident who is a victim of sexual abuse at the facility would be offered timely follow-up for sexually transmitted diseases is part of the follow-up with medical. This would occur if the victim was tested at the hospital or not.

These were no incidents of sexual abuse or sexual assault occurring at the facility during the past twelve (12) months. In the event that an incident was to occur, the victim would receive services from the community provider. All on-going medical care beyond the scope of facility medical staff would be provided by community providers.

Reviewed documentation to determine compliance:

- LSS PREA Policy

Interviews:

- Interview with Program Director
- Interview with nurse
- Interview with mental health practitioner

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

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

115.386 (a)

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

115.386 (b)

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

115.386 (c)

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

115.386 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No

- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.386 (e)

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

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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LSS PREA Policy states within 30 days of the conclusion/receipt of a sexual abuse investigation, the facility shall conduct a Sexual Abuse Incident Review of all allegations (Substantiated or Unsubstantiated), unless the allegation has been determined to be Unfounded. The Facility Director shall convene a review team, at a minimum of upper-level management officials. The Review Team shall obtain input from direct supervisors, investigators, medical, mental health professionals, and other employees as appropriate. In addition, the Review Team must:

1. Consider whether the allegation or investigation indicated a need to change policy or practice to better prevent, detect, or respond to sexual abuse;
2. Consider whether the incident or allegation was motivated by perceived race, ethnicity, sex, gender identity, sexual orientation, status, gang affiliation, or motivated by other group dynamics at the facility;
3. Examine the area of the facility where the incident allegedly occurred to access whether the physical layout may enable abuse;
4. Assess the adequacy of staffing levels in that area during different shifts;
5. Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff;

6. Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to this section, and any recommendations for improvement and submit such a report to the Facility Director.

LSS will conduct PQI review at the conclusion of every quarter that will include follow-up from the monthly sexual abuse incident review. The review team will review the recommendations from the program level review team and determine if any agency-wide policy changes are necessary and implement the recommendations for empowerment, or shall document its reasons for not doing so.

The Agency PREA Coordinator stated the Incident Review Team consists of upper-level management officials. A member of the Incident Review Team was interviewed during the on-site portion of this audit and was able to describe the review process that would take place in the event an allegation of sexual abuse was either Substantiated or Unsubstantiated. He stated the Incident Review Team would convene within thirty (30) days upon the completion of an investigation. Recommendations would include examining the need to change a policy or practice to better prevent, detect, or respond to sexual abuse or sexual harassment. This auditor was provided a copy of the PREA Sexual Abuse Incident Review template to review.

There were no incidents within the past twelve (12) months that have required an incident review.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- Sexual Abuse Incident Review Form

Interviews:

- Interview with Agency PREA Coordinator
- Interview with Incident Review Team member

Standard 115.387: Data collection

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

115.387 (a)

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

115.387 (b)

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

115.387 (c)

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

115.387 (d)

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

115.387 (e)

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

115.387 (f)

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

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

According to LSS PREA Policy, LSS collects uniform data for every allegation of sexual abuse at facilities under its direct control using a standardize instrument and set of definitions. Arise Youth Center – West collects this information monthly. This collected data includes all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. The Agency PREA Coordinator shall aggregate the incident-based sexual abuse data at least annually. The incident-based data collected includes, at minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice. Upon request, the facility shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

An interview with the PREA Coordinator indicated that she keeps detailed records for all incidents to generate his annual report and/or data required by the United States Department of Justice. There were no allegations of sexual abuse during the past twelve (12) months.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- 2020 Annual PREA Report
- DOJ 2020 Annual Survey

Standard 115.388: Data review for corrective action

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

115.388 (a)

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

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

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.388 (b)

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

115.388 (c)

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

115.388 (d)

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

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy states that LSS shall review data collected and aggregated pursuant to Standard 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training including:

1. Identifying problem areas
2. Taking corrective action on an on-going basis
3. Preparing an annual report of its findings and corrective action.

These statistics are provided to the South Dakota Department of Corrections (SDDOCS). The SDDOC develops a report for Lutheran Social Services (LSS). This report includes a comparison of the current year's data and corrective actions with those from the prior years and provides an assessment of LSS progress in addressing sexual abuse. This report is approved by the Lutheran Social Services head and available to the public on the SDDOCS website. Specific materials are redacted that may present a clear and specific threat to the safety and security of the agency/facility.

This survey was completed by the Agency PREA Coordinator on June 1,2021 and sent to SDDOC.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- PREA Annual Report (2020)

Interviews:

- Interview with Program Director
- Interview with Agency PREA Coordinator

Standard 115.389: Data storage, publication, and destruction

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

115.389 (a)

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained? ☒ Yes ☐ No

115.389 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.389 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.389 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

LSS PREA Policy requires that aggregated sexual abuse data from facilities under the control of Lutheran Social Services (LSS) was readily available to the public annually through the South Dakota Department of Corrections (SDDOCS) website. LSS prepares this data in a monthly report and submits it to the SDDOCS in order to develop the annual report. The SDDOCS breaks down the data by specific facilities under LSS direct control. Data collected is retained for ten (10) years after the initial collection, unless Federal, State, or local law requires otherwise. It is retained in an electronic database that is only accessible to select staff.

Interview with the Agency PREA Coordinator noted that no personal identifiable information is included in the report. The most recent Annual PREA Report (2020) was sent to the SDDOCS website. SDDOCS does not post the reports any longer so they are posted on the agency website.

Reviewed documentation to determine compliance:

- LSS PREA Policy
- PREA Annual Report (2020)

Interviews:

- Interview with Program Director
- Interview with Agency PREA Coordinator

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

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

115.401 (a)

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

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard*.) ☒ Yes ☐ No

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

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

115.401 (h)

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

115.401 (i)

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

115.401 (m)

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

115.401 (n)

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

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

The facility was audited in 2018 during the second year of the second three-year cycle. The facility was found to be in full compliance on October 25, 2018. This re-audit occurred during the second year of the 3rd three-year PREA cycle on October 24-25, 2021.

The facility provided all requested information via e-mail. The audit notification was posted of this audit (posted on August 22, 2021), and pictures of the notifications posted in all common areas, and housing unit were submitted to this auditor via e-mail. During the tour of the facility, the notifications were still posted and viewed by this auditor. This auditor did not receive any correspondence from staff or youth. This auditor was permitted to and did tour all areas of the facility; and was provided a confidential area of the facility to complete interviews of residents and staff.

The facility has met this standard by having its facility audited during the three-year cycle. The report is posted on its website.

Reviewed documentation to determine compliance:

- Pre-Audit Questionnaire
- Tour of facility
- LSSSD website
- PREA Audit Notification
- Photographs of PREA Audit Notification

Standard 115.403: Audit contents and findings

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

115.403 (f)

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

Auditor Overall Compliance Determination

☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)

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

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

Instructions for Overall Compliance Determination Narrative

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

Final PREA audit report from the second cycle is posted on the LSSSD website. The final PREA report was posted within ninety (90) days of issuance by the auditor. This was confirmed by reviewing the LSSSD website and an interview with the Agency PREA Coordinator.

Reviewed documentation to determine compliance:

- LSSSD website

Interview:

- Interview with Agency PREA Coordinator

AUDITOR CERTIFICATION

I certify that:

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

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

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

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Farooq Mallick November 23, 2021

Auditor Signature **Date**

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.