PREA AUDIT: AUDITOR'S SUMMARY REPORT
JUVENILE FACILITIES

[Following information to be populated automatically from pre-audit questionnaire]			
Name of Facility:	The Larned Juvenile Correctional Facility (LJCF)		
Physical address:	Larned, Kansas		
Date report submitted:	Initial Report: September 10, 2014	Final Report: September 17, 2014	
Auditor Information:	Candy Snyder		
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Telephone Number:	605-673-2521		
Date of facility visit:	August 25th to August 27th		
Facility Information			
Facility mailing address: ***(if different from above)***	1301 Kansas Highway 264 Larned, KS 67550-9365		
Telephone Number:	(620) 285-0300		
The Facility is:	☐ Military	☐ County	☐ Federal
	☐ Private for profit	☐ Municipal	☒ State
	☐ Private not for profit		
Facility Type:	☐ Detention	☒ Correction	
Name of PREA Compliance Manager: Susan Prescott			**Title:** PREA Compliance Manager
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Agency Information			
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Governing Authority or Parent Agency: *(if applicable)*			
Physical Address:	714 S.W. Jackson St., Suite 300, Topeka, KS 66603		
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Agency Chief Executive Officer			
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AUDIT FINDINGS

NARRATIVE:
The Larned Juvenile Correctional Facility (LJCF) is a 152-bed juvenile facility that houses the Kansas Department of Corrections' substance abuse and mental health treatment facility for young male residents. The PREA Audit took place on August 25th through August 27th. At the time of the audit the youth population was 121 students.

Prior to arrival at LJCF the auditor reviewed pertinent agency policies, procedures, and related documentation used to demonstrate compliance with PREA standards. The documents provided prior to the on-site portion of the audit were very well organized and very easily followed by the auditor. The on-site portion of the audit began with an entrance briefing with the purpose of organizing the audit schedule. The meeting was attended by the following staff: Wendy Leiker, Superintendent; Talia Huff, the PREA Coordinator; Susan Prescott, the PREA Compliance Manager; Major Brad Collins, Juvenile Corrections Director; Doug Lawson, Deputy Superintendent; Mark Mora, Corrections Counselor II; C.J. Perez, Corrections Counselor II; Rob Manry, Business Manager; Cindy Stejska, HR Manager; Anita Ellison, Program Director; Julie Snodgrass, Staff Development; Kevin Stegman, EAI Investigator; and Dr. Nicole Tice, Health Services Administrator. The PREA compliance manager provided the auditor with a list of staff and a list of residents by housing unit. The auditor toured the facility accompanied by several of the key staff. During the tour the auditor informally questioned staff to gain better understanding of the facilities standard operating procedures. The auditor then began the interview portion of the audit. The auditor interviewed 19 staff. The staff composition included ten direct care staff, one volunteer, two contractors, the Agency Head, the Superintendent, the PREA Coordinator, the PREA Compliance Manager, the facility Human Resources Manager, the facility investigator and the Health Care Administrator. The auditor interviewed 11 residents. The residents were selected both randomly and from a roster with specific characteristics in mind to include: 1) all housing areas, 2) varying lengths of stay 3) residents who identified as gay or bisexual, and 4) residents who had been involved in a facility investigation. There were no residents that identified as transgendered or intersexed and there were no residents who needed translation services or other disability related services. There were no residents who requested to speak with the auditor. Finally, the auditor completed a review of all pertinent policies, records, and documents. An exit interview was held with the PREA Coordinator and the PREA Compliance Manager.

DESCRIPTION OF FACILITY CHARACTERISTICS:
LJCF has seven general population units, two mental health units and one special management unit. All units are surrounded by a secure perimeter fence. The 152-bed facility has 90 medium-security beds dedicated to the Residential Substance Abuse Treatment (RSAT) Program. Offenders are sent to this program from the Kansas Juvenile Correctional Complex after an extensive evaluation. An additional 30 beds are dedicated to offenders transitioning from the RSAT Program back to the general population. The remaining 32 beds are classified as maximum security and are dedicated to mental health treatment.

Education
The KDOC contracts with Fort Larned USD 495 for educational services. Housed within the facility, students attend Westside High School. Students can earn a high school diploma, their GED or college credits. They can also attend class in vocational education to include welding, carpentry and culinary arts.

Programs
LJCF utilizes the Pathways to Self-Discovery and Change substance abuse curriculum and incorporates individualized treatment and relapse prevention services provided by licensed Chemical Dependency Counselors.

Corrections Counselors provide evidence-based programming such as Thinking for a Change and Aggression Replacement Training (ART). Two certified Offender Workforce Development Specialists assist youth in preparing juveniles for re-entry into the community. Other programs offered include Violent Offender, Sex Offender, Independent Living Skills and Parenting classes. Offenders also obtain work skills through vocational programming such as: dietary, laundry, environmental services, woodshop and yard maintenance.

History
The Larned Youth Rehabilitation Center was established at Larned State Hospital in 1972. In 1982, the Kansas Legislature established a youth services division in the Department of Social and Rehabilitation Services (SRS), and the Larned Youth Rehabilitation Center was renamed the Youth Center at Larned. At the same time, the bed capacity was doubled. The Center was expanded again in 1994 to 116 beds. The facility was renamed the Larned Juvenile Correctional Facility in 1997. On July 1, 1997, responsibility for the juvenile correctional facilities was transferred from SRS to the newly created Juvenile Justice Authority. In 2013 the Juvenile Correctional Authority came under the direction of the Kansas Department of Corrections.

SUMMARY OF AUDIT FINDINGS:
All interviews and observations by the auditor indicated that practice follows the procedures outlined in policy. Residents felt very comfortable reporting information to staff. Staff were well trained in how to handle all incidents swiftly, appropriately and with confidentiality.

All residents reported that they feel safe at LJCF. All residents reported at least two methods of reporting. The facility had posters placed throughout the facility, the youth stated they had the PREA brochure provided upon intake to refer to throughout their stay. There were phones located in each housing unit and the youth were very familiar with how to contact the hotline using the phone.

All staff were familiar with how to perform their responsibilities in prevention, detecting and responding to incidents of sexual abuse and sexual harassment. They carried on their persons a laminated yellow card with prompts for response and emergency numbers to reach key contact people in the event of sexual assault. Staff were able to relay to the auditor signs to watch for in residents who may have experienced sexual abuse or harassment. The facility staff assigned to monitoring for retaliation was very proficient in the duties necessary to detect and monitor for retaliation. Specialized staff were very knowledgeable in their roles and had received specialized training in their areas of expertise.

The auditor reviewed documentation to include background checks, applications, signed staff training records, resident records acknowledge receipt of PREA training, documentation of unannounced supervisory rounds and investigative files. The investigative reports indicated a thorough investigation.

The auditor found Larned Juvenile Correctional Facility to be materially compliant with all PREA Juvenile Standards.

Number of standards exceeded: **1**

Number of standards met: **40**

Number of standards not met: **0**

Non-Applicable standards: **1**

Standard 115.311 Zero tolerance of sexual abuse and sexual harassment

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

There is a written policy stating the facility's zero-tolerance for sexual abuse and sexual harassment. Policies outlined the facility's efforts in preventing, detecting and responding to sexual abuse and harassment. Policy included all necessary and related defined terms. In addition, it was evident through the interviews and the tour that LJCF has a culture of zero tolerance. The PREA Coordinator meets monthly with all Compliance Managers. The PREA Compliance Manager of LJCF works very hard to ensure every staff has all that is needed to comply with PREA Standards and that every action the facility takes is in an effort to ensure youth are safe at the facility.

Standard 115.312 Contracting with other entities for confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

This standard is not applicable, as Larned Juvenile Correctional Facility does not contract with other facilities for the confinement of its residents.

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

There was a good Annual Staffing Plan. Currently LJCF has a 1:8 ratio on their special management units, segregation units and mental health units. However, they still have a ratio of 1:16 on their open units during the day. Although they do not meet the 1:8 ratio fully in all units, they are working toward that goal with the intent of meeting the ratio by 2017. They have good documentation of unannounced rounds by intermediate and higher level supervisors. Supervisory personnel are conducting unannounced rounds on all shifts and documenting those rounds. Documentation was reviewed and found to be compliant.

Standard 115.315 Limits to cross gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

LJCF has policy that prohibits female staff from conducting cross gender searches of male youth, except in exigent circumstances. This is a relatively new policy at LJCF. Staff have done very well in implementing this change. All interviews with both youth and staff confirmed the policy. Early in the year there was one incident of a female staff conducting a pat search. The auditor reviewed the circumstances surrounding the incident and concurred that it met the criteria of an exigent circumstance. The incident occurred prior to the development of their exigent circumstance log. The facility has not had transgender or intersex residents but

policy prohibits examination for the sole purpose of determining gender and staff are knowledgeable in the policy. Staff are adequately trained in searches of gay and bi-sexual residents, and such training is required by policy. Youth shower in private showers with locked doors to provide privacy and to prevent observation by female staff or casual observers. Youth are assigned individual rooms with a toilet/sink. There are 32 beds in the mental health and special management units that have cameras that can be viewed from the control room area. This area is supervised by female staff. Initially this practice was found to not be compliant with the standard. However, while the auditor was still conducting the audit, facility staff blurred out the toilet area of all 32 cameras. The auditor was brought back to view the cameras and verified that adequate privacy for the youth while toileting was accomplished through their modification. The facility is to be commended for their quick response – evidence to their commitment to doing whatever it takes to comply with all PREA standards.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

LJCF does a very good job of providing materials to the few residents that do not speak English, primarily their Spanish-speaking residents. They have materials available such as posters and educational materials. There is a language translating service available, The Big Word, for those residents that may arrive who do not speak English proficiently. This service is set up to be accessible 24-hours a day. Staff had knowledge of the available translating service. Policy prohibits using resident interpreters. Although there were no documented residents with disabilities, staff were aware of the expectations of providing necessary services.

Standard 115.317 Hiring and promotion decisions

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

The auditor reviewed personnel records and all staff hired or promoted over the reporting period had the required background checks. They perform background checks on existing employees every year versus every five years, exceeding the standard. The three questions required by the standard regarding any previous misconduct were on the employment application. The facility conducts checks with all previous institutional employers regarding substantiated allegations of sexual abuse. Staff are informed of their continuing duty to report and sign the policy to acknowledge this. Agency policy states that material omissions in applications regarding such misconduct, or the provision of materially false information, shall be grounds for termination. The facility has policy to provide information to other institutions on former employees that engage in sexual abuse or harassment. The Human Resource Manager's records were impeccably maintained.

Standard 115.318 Upgrades to facilities and technology

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

The facility is relatively new – constructed in 2003. Spaces were constructed to allow for direct supervision. Each unit has a control area that allows for constant supervision of youth within the housing unit. They have installed new cameras and have plans to make additional upgrades to the camera systems in efforts to better

prevent and detect sexual abuse and harassment. The upgrades will also allow for a longer retention period of recorded video.

Standard 115.321 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

The facility has a recently assigned facility investigator who conducts all investigations. If an incident is criminal he works with the local prosecutor to ensure all evidentiary requirements are met. The facility has an MOU with the Family Crisis center in Great Bend for advocacy services and uses a SANE nurse at the local hospital – Great Bend Regional Hospital to conduct forensic exams.

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

The facility refers all allegations for investigation. Investigations occurring during the reporting period were completed by qualified investigators and required documentation and reporting occurred, as required by policy. Administrative and criminal investigations are conducted by facility investigators that received specialized training.

Standard 115.331 Employee training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

Staff were very well trained in the correct first responder response – Separate, provide care, protect evidence, call for assistance, notify shift supervisor and provide a written report. Although the training emphasized keeping the incident confidential, a few youth reported they felt incidents were not kept confidential. They felt when something was reported it was sometimes made known to other staff and to other youth. The auditor recommends that training continue with staff that emphasizes the confidentiality of PREA reports and that staff work on building the trust with youth that information they share with a line staff will not be shared with others. The yellow first responder cards that staff carry were a very useful tool to help staff identify proper steps until those steps become second nature to them. Staff were also very well versed in how to recognize signs of sexual abuse in youth and how to communicate effectively with LGBTI youth. Not all staff were as thoroughly versed in Kansas law for a mandatory reporting and the age of consent. The auditor recommends strengthening training in these laws.

Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

The facility provided quality training to volunteers and contractors as verified through both training records and through interviews.

Standard 115. 333 Resident education

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

Youth receive a brochure on the day of arrival that outlines important PREA information. They keep these brochures with them to refer to throughout their stay. This training is followed up with an in-person training that is presented either by the Chaplain or the PREA Compliance Manager. The interviews confirmed that all youth were well aware of how to report and were familiar with multiple ways to report. All youth felt the LJCF was a very safe environment. Training can be strengthened so that the residents are aware that the person that answers the hotline is not an employee of the DOC. The youth acknowledged receiving orientation in writing and that documentation was reviewed.

Standard 115.334 Specialized training: Investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

The facility has a recently assigned investigator. He had previous experience as a law enforcement officer through the state highway patrol and in the capacity attended the training academy. In addition he has completed the “Specialized Training for Investigators” course offered by the NIC.

Standard 115.335 Specialized training: Medical and mental health care

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

Medical and mental health practitioners received the training as required. Medical personnel do not conduct forensic examinations. Training was documented.

Standard 115.341 Screening for risk of victimization and abusiveness.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

The facility screens all residents. The screening information is appropriately protected and only shared with those that need to make informed housing and work assignment decisions. The Kansas Juvenile Correctional Complex (KJCC) in Topeka provides intake and orientation for all youth coming into the DOC. A

screening is completed at KJCC immediately prior to the youth being transported to LJCF using the KDOC Juvenile Services Screening for Victimization and Abusiveness (SVA) form. The DOC has a policy of completing a SVA for all inter-facility transfers by the sending facility before a youth is transferred. A few youth did not recall being asked at LJCF the specific questions as to how they identify themselves as gay, straight or bisexual; if they had learning disabilities; or if they were fearful at being housed at LJCF. LJCF does complete a Sexual Assault and Vulnerability Questionnaire upon arrival that asks a portion of the required questions. The auditor recommends that the complete SVA screening be completed at LJCF upon arrival as youth often can change how they answer screening questions based on the specific environment they are it at the time of the screening.

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

LJCF staff use the screening information to determine housing unit placement and work assignments. They have a protocol for ensuring that known aggressors are not placed with potential victims. LJCF states there have been no transgender or intersex residents placed at the facility. However, if there were to be in the future, housing assignment would be done on a case-by-case basis considering the residents own views of safety. During the interviews a few staff were not able to portray to the auditor how the facility would accommodate transgendered and intersex youth. A few staff felt that only anatomically male youth would ever be placed at LJCF. Although the decision on housing assignment is made by others, line staff need to be familiar with how the decisions are made so that they may support the decision within the housing unit. A few staff stated that assignment to LJCF is made when the youth is anatomically male as determined by self-disclosure or medical examination. The standard states that in deciding whether to assign a transgender or intersex resident to a facility for male or female residents that the agency shall consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems. The PREA Coordinator stated that they have more in-depth training on LGBTQI youth scheduled for the upcoming year. All residents at the facility shower separately.

Standard 115.343 Protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

Typically residents at higher risk for sexual victimization are kept in the general housing area. Protective Custody is typically only used at the request of the resident. While in segregated housing residents still have access to programs, privileges, education, and work opportunities.

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

The agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about: sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents**.** Residents can report allegations to someone outside of the facility through the

use of a hotline that is answered by Child Protective Services. All youth were very aware of the hotline and how to use it. The auditor recommends that youth are informed that even if the person answering the hotline requests their name, they can remain anonymous upon request.

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

The facility has an established procedure for filing and resolving grievances and grievances may be filed on behalf of a resident. Emergency grievances may be filed. None were filed during the reporting period. The agency has a written policy that limits its ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith. This did not occur during the reporting period. Grievances must be resolved within listed time frames. Grievances were resolved within those time frames with no extensions needed.

Standard 115.353 Resident access to outside confidential support services.

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

Residents have access to outside confidential support services. The facility has an agreement with the Family Crisis Center in Great Bend for advocacy services. The residents interviewed all stated that they also may contact attorneys and/or parents. The auditor recommends an increase in parental/guardian contact. A youth may be more apt to discuss problems with a parent that they may never disclose to anyone else.

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

The facility is compliant. Youth case managers work with parents and others involved with the youth and provide a means for parents and family to report. Also, the hotline number for Child Protective Services is provided on the DOC website. The auditor recommends that the facility strengthen this area by providing an introductory letter to parents with contact information. Although the website lists the number for contacting the hotline for Child Protective Services, the auditor recommends that they more clearly state on their website a statement more closely tied to PREA and sexual abuse as a reason for using the hotline number.

Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

The facility's policy describes requirements for all staff to include medical and mental health practitioners to immediately report any knowledge, suspicion or information received related to sexual abuse/harassment incidents, retaliation and staff negligence that may have contributed to such incidents. Staff are required to make such reports to the shift supervisor and all shift supervisors ensure a report is submitted to the investigator. Random staff interviews confirmed their responsibility to comply with facility policies and to maintain that information in confidence. The yellow First Responder wallet cards verified their procedures and many staff interviewed showed the auditor their cards. There were no allegations of sexual abuse the facility received from other facilities. The facility superintendent, Agency PREA Coordinator, and the facility PREA Compliance Manager all supported their adherence to reporting standards and responsibilities. Policy requires that outside investigators be informed when there is suspected criminal activity.

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

The facility requires all staff to take immediate action to protect the resident from imminent sexual abuse. There have been no instances that the facility determined that a resident was subject to risk of imminent sexual abuse. Interviews confirmed compliance with expected practices. Administrators and line staff understood and agreed that "immediate" means when the response is needed. That is situational determinant such within moments of receiving the allegation or no later then by the end of the shift.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

Interviews with the Superintendent and PREA Compliance Manager confirm actions that will be taken upon receiving an allegation of sexual abuse while a resident was at another facility. Such action will be initiated no later than 72 hours and actions will be documented. These steps were also noted in the review of policies and procedures. There have been no instances of these allegations received from other facilities.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

Facility policies comply with this standard. Interviews with staff verified and the First Responder wallet card verified their process to provide assistance, separate alleged victim/abuser, preservation and protection of evidence by securing the scene including the request of the victim not to take any actions which could destroy any physical evidence. All staff have been trained accordingly.

Standard 115.365 Coordinated responses

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

The facility coordinates actions to be taken when an incident occurs. This plan coordinates actions among staff, first responders, medical/mental health staff, investigators and facility leadership. Staff interviews and interviews with the Superintendent and PREA Compliance Manager indicate that staff are aware of their responsibilities to coordinate responses within the facility.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

The administrators will remove alleged staff sexual abusers from contact with residents pending the outcome of the investigation. The facility employs represented (union) employees. However, The facility is not restricted in any way from protecting residents from contact with abusers.

Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

The facility has a written policy related to protection against retaliation. The PREA Compliance Manager is charged with monitoring for retaliation. Should any person who cooperates with a sexual misconduct investigation express fear of retaliation; appropriate protective measures will be taken. Retaliation monitoring will be discontinued should the allegation be unfounded. Measures include housing changes, removing contact of alleged staff/resident abusers and emotional support services for those who fear retaliation. Interviews with the PREA Compliance Manager confirmed her duties and responsibilities. There have been no instances of alleged retaliations.

Standard 115.368 Post allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

The facility policy states that they shall consider alternatives to isolation for all offenders who report sexual abuse or sexual harassment rather than placing them in segregation or protective custody. Offenders placed in protective custody shall be tracked to ensure they are provided access to programming, education, and activities in the least restrictive setting possible. The facility had no documented instances of youth in segregation during the reporting period for the purpose of protective custody. A youth did report during the interviews that they could be placed in segregation for protection purposes and felt that this would be punishment. The auditor recommends that the practice of protective custody be replaced with close observation practices. The facility stated they would use protective custody only if it is specifically requested by the victim.

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

The auditor reviewed documented investigations and determined all standards are being properly followed for both administrative and criminal investigations. Through interviews with the investigator and the PREA Compliance Manager it was determined that investigations are not terminated should the source of the allegation recant. Should criminal prosecution be considered the investigator coordinates with the prosecutor. Polygraph tests are not used in the course of their investigations. Administrative investigations will include efforts to determine whether staff actions/failures contributed to the abuse documented through written reports, which will include physical/testimonial evidence, credibility assessments and investigative facts and findings. All written reports will be retained for at least seven (7) years from resident discharge or until the age of majority is reached whichever is longer. Investigations will not be terminated due to the departure of an alleged abuser or victim.

Standard 115.372 Evidentiary standards for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

Facility policy stipulates no standard higher than a preponderance of evidence will be used in making a determination of alleged sexual abuse/harassment. Through the interviews with the investigator and the PREA Compliance monitor there was confirmation that the facility uses no standard higher than the preponderance of evidence in making final determinations of sexual abuse/harassment.

Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

Facility policy requires residents to be informed as to whether the allegation was substantiated, unsubstantiated or unfounded. If a sexual misconduct allegation is confirmed, the resident will be informed of the abuser's status; and as appropriate of an indictment/conviction. Interviews with the Superintendent, PREA Compliance Manager and youth confirmed practices involving all standard components were in place. There were no allegations involving staff during the reporting period. A youth involved in an investigation was interviewed by the auditor. He stated that he felt the situation was handled appropriately and he was notified of the outcome.

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

No staff have violated agency sexual abuse or harassment policies. Interviews conducted with the Superintendent, Investigator and PREA Compliance Manager verified that there have been no substantiated allegations at the facility during this audit period. Interviews also confirmed that agency policies would be followed should disciplinary measures be required including a report to Child Protective Services, the Prosecutor's office and relevant licensing authorities should termination and/or resignation of staff occur.

Standard 115.377 Corrective actions for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

Contractors and volunteers are subject to disciplinary actions including termination for violation of agency sexual abuse/harassment policies. According to the Superintendent and the PREA Compliance Manager, should any violation of this type be substantiated, the facility has complete authority to administer remedial measures including prohibiting further contact with residents. They also verified that if disciplinary measures are required it could also include a report to Child Protective Services, the Prosecutor's office and relevant licensing authorities. Through the interview with a volunteer and contractors, it was confirmed that they are informed that they are subject to disciplinary actions including termination for violation of agency sexual abuse/harassment policies.

Standard 115.378 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

The facility prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred. The facility offers counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. If findings of resident on resident sexual abuse, administrative sanctions will be administered following the formal disciplinary processes applied commensurate with the level of infractions. Residents indicated in interviews that they are aware that should the need arise, there are staff who will assist them with obtaining appropriate counseling. Residents' access to general programming or education is not conditional on receiving interventions designed to address/correct underlying reasons or motivations for abuse.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

Residents are seen by medical and mental health personnel as required in the standard, including follow-up visits. Information on resident sexual abuse is restricted to those that need to know. Facility policies are complete on all standard elements. There were no residents who disclosed a prior sexual victimization. Interviews confirmed agency policy expectations and staff were aware of their responsibilities including limiting information strictly to medical/mental health and other staff as necessary. Medical and mental health staff was also aware of mandatory reporting laws for residents under the age of 18 years.

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

Emergency medical response was not needed during the review period. A review of facility policy documented PREA requirements for access to emergency medical and mental health services. Emergency services would be provided by Great Bend Regional Hospital. Emergency medical and mental health services are provided without charge to residents.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

The facility as identified in agency policy offers medical/mental health evaluations and treatment at no cost to sexual abuse victims and abusers. Victims and abusers are provided with appropriate medical and mental health treatment. Policy requires treatment and interventions occur, and review of facility practices strongly indicates that those treatment and interventions, and the timeliness of responses are consistent to the level of community care. There were no incidents of sexual abuse reported during the period that included sexual penetration so information on STDs does not apply. The facility is a male-only facility so the pregnancy portions of the standard are not applicable.

Standard 115.386 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

The facility conducts a sexual abuse incident review following each sexual abuse investigation regardless of final determination of findings, unless unfounded. Residents may be assigned to another living unit to increase supervision capabilities. Upper-level staff has received incident review training which allows for input from supervisors, investigators, medical or mental health staff.

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

The facility collects uniform data for all allegations of sexual abuse based on incident reports, investigation files and incident reviews. Aggregate annual data from LJCF and other state facilities are available through the statewide Enforcement, Apprehensions, and Investigations (EAI) Division Case Log, an on-line web

based application. The PREA Coordinator extracts all the data for review and reporting purposes. The agency has provided this information through the Survey of Sexual Violence as well as on the DOC website.

Standard 115.388 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

The PREA Compliance Manager and Incident Review Team review all incidents for corrective action measures. The annual report provides data collected in 2013 and will compare data collected from 2014 to the previous year and will track progress on all recommended corrective actions. The annual report for 2013 is located at http://www.doc.ks.gov/publications/kdoc-facilities-management/prea/report. In addition the facility's PREA Compliance Committee meets once each week. Any incidents as well as efforts toward PREA Compliance and corrective actions are discussed. All DOC facility PREA Compliance Managers meet monthly with the PREA Coordinator where again all issues are discussed.

Standard 115.389 Data storage, publication and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor comments, including corrective actions needed if does not meet standard

Data collected is retained via limited access and through a secure server for at least ten (10) years. The Agency's website posting of 2013 PREA annual report is located at:

http://www.doc.ks.gov/publications/kdoc-facilities-management/prea/report

AUDITOR CERTIFICATION:

The auditor certifies that the contents of the report are accurate to the best of her knowledge and no conflict of interest exists with respect to her ability to conduct an audit of the agency under review.

Candace L. Snyder
Auditor Signature

September 17, 2014
Date