PREA AUDIT:

AUDITOR'S FINAL SUMMARY REPORT

Name of Facility: Perseus House: Boys' Intensive Treatment Program			
Physical Address: 516 W. 7th Street Erie, Pa. 16502			
Date report submitted :September 2, 2015			
Auditor information: Maureen G. Raquet			
Address: P.O. Box 274, Saint Peters, Pa. 19470-0274			
Email: mraquet1764@comcast.net			
Telephone number: 484-366-7457			
Date of facility visit: May 11,12,13,14, 2015			
Facility Information: same as above			
Facility Mailing Address: same as above			
Telephone Number: 814-453-6389			
The Facility is:	☐ Military	County	☐ Federal
	☐ Private for profit	☐ Municipal	☐ State
	☐ xxx Private not for profit		
Facility Type:	☐ Juvenile Detention	☐ Correction ☐ xxx Juvenile Treatment Facility	
Name of PREA Compliance Manager: Debbie Malory Title: PREA Manager/Facility Director			
Email Address: dmalory@perseushouse.org		**Telephone Number:**	s/a
Agency Information			
Name of Agency; Perseus House			
Governing Authority or Parent Agency:			
Physical Address: 1511 Peach Street, Erie, Pa 16501			
Mailing Address: s/a			
Telephone Number:814-480-5900			
Agency Chief Executive Officer:			
Name: Mark Amendola		**Title:**	Chief Executive Officer
Email Address: mamendola@perseushouse.org		**Telephone Number:**	s/a
Agency Wide PREA Coordinator			

Name: Mark DiPlacido	**Title:**	Chief Operating Officer
Email Address: mdiplacido@perseushouse.org	**Telephone Number:**	s/a

AUDIT FINDINGS

NARRATIVE: Perseus House was established in 1971, originally as a Community Service Project. It has since grown to become a multi-faceted agency that includes two separate components: a Charter School Program and Juvenile Residential programs. The Charter School offers alternative education for middle and high school students in the Erie School District at 3 different sites and serves over 600 children. There are nine residential programs, with a total of 96 beds, including a mother/baby program, a shelter, an Intensive Treatment Program for sex offenders, three RTFs, two "enhanced" RTFs, and a Girl's Intensive Treatment Unit. In 2014, there were 73 total admissions for the agency. The Audit was conducted on May 11, 13, 14, 2015 at the Boys' Intensive Treatment Program, an all-male program with 10 beds. This is a low-level sex offender program. Both dependent and delinquent children can be court ordered to this placement. There were 8 residents in-house during the dates of the audit. During 2014, there were 5 admissions ranging in age from 12-18 and the average length of stay is 12-14 months.

This private agency is run by the Chief Executive Officer, Mark Amendola. Perseus House has 168 full time and 61 part time employees. The Agency contracts with 25 Pennsylvania Counties. The direct care or line staff are full and part time and most work permanent shifts. The Boys ITP Program has 12 staff. The facility is licensed by the Pa. Department of Human Services, under the 3800 regulations, has received certification in the Sanctuary Program which is the organizational culture of the Agency and has JCAHO accreditation. Perseus House also serves as a National Training Site for Life Space Crisis Intervention and ART.

DESCRIPTION OF FACILITY CHARACTERISTICS: The Boys' Intensive Treatment Program is located in a mixed use residential neighborhood in the City of Erie, Pa. It sits on a large lot, under an acre, on a residential street. The street also hosts a Women's Shelter and a College Fraternity. The 5,005 square foot older Victorian Home, was purchased by Perseus House in the 80's and has two floors and a basement. The front door opens into a foyer area with a television and then two separate living rooms/community rooms used for groups and visiting. It is furnished comfortably, with large windows and built in shelving and ornate woodwork. This living room is used for group and has comfortable furnishings. On the other side of this house, is the Nurses' office, where Intakes are conducted, a small office area, for files, and a dining room, with a large table for family style meals. Directly behind the dining room is the kitchen and a stairway with access to the basement and an exit to the rear yard.

The second floor is accessed by a very wide stairway with a landing half way up with large windows. There are 3 bedrooms: two quads with bunk beds and a double, which was not in use at the time of the Audit. Each room has an open closet. There is a hall bath, with a tub/shower combo, sink and toilet and a sign in sheet for bathroom use. The double room has a bathroom attached, with a shower, sink and toilet. All residents shower separately. Also on this floor is the Director's office in the front of the building and the MH therapist office. I also saw where the overnight staff person is stationed for line of view.

A small basement is accessed from the first floor. It has three separate open areas that contain athletic/recreation equipment: weights/machines, etc.

This building does not have cameras and it is staff secure.

SUMMARY OF AUDIT FINDINGS:

The audit was conducted on May 11, 13, 14, 2015. It commenced with an entrance meeting at the Agency's Central Administration Building in Erie with the following: the Associate Executive Director, the COO/PREA Coordinator, the Nursing Coordinator, Human Resources Director and the three PREA Managers for each Facility being audited during this time period. Following this orientation meeting, interviews with several of the specialized staff, common to each facility took place. This included the Associate Executive Director, the COO/PREA Coordinator, and the Human Resources Director. I interviewed the CEO, by phone, subsequent to the on-site Audit on 5-20-15. On May 13, 2015, I toured this facility. The facility was very clean and well maintained. The residents were just rising and doing morning chores upon my arrival at 7:00 AM, but left soon thereafter to attend school off premises. During my tour of the building, I saw postings regarding zero tolerance, reporting, and victim support services in several areas in both English and Spanish. I saw the "Hotline Button" on the private phone in the Therapist's Office. Only the Director and Nurse were present in the facility at the time of the tour, because staff and residents were at school. During the tour, the nurse showed me documentation of both the risk assessment administration, resident education and secondary documentation of follow up by Medical and Mental Health. The Nurse administers the Vulnerability Assessment and educates the children regarding reporting and the Zero Tolerance Policy. She also does a Health and Safety Assessment on each child upon Intake. There are only 12 staff who work at the ITP and I interviewed 9 random staff from all three shifts (including one by phone who was out on sick leave). All residents, (8), the entire population at the time of the Audit, were interviewed at the school, about two miles away, where they are transported everyday by van. This is an old Catholic school purchased by Perseus House. Both non-residential Alternative School children attend, as well as residents from the various group homes. There is a principal as well as teachers, disciplinarians, etc. The residential children are kept separate from the Alternative School children. I met the residents individually in a private office and they could tell me about PREA and all were well aware of the Zero Tolerance Policy, and various methods to report. Of the 8 boys, I interviewed, three stated they had been previously victimized. I interviewed the following staff: Facility Director/PREA Manager, who also is responsible for monitoring retaliation and conducting random unannounced rounds, a Nurse, and a Masters' Level Mental Health Therapist. There were no volunteers or contractors specific to this facility to interview. A binder of signed Zero Tolerance Acknowledgements for any delivery person, etc. is kept. There were no LGBTI residents. I reviewed 8 resident files and 12 staff files.

The residents have a plethora of ways to report sexual abuse. There is a one button hotline in the Director's office to Child Line. There is an MOU that the residents can send letters to the Erie County Sheriff's office. There is a grievance policy that both residents and parents are advised of at Intake. They can write to the facility director or the agency director. In addition besides telling line staff, which all residents stated they felt comfortable doing, they have weekly individual counseling sessions. Many also have weekly family counseling sessions, in addition to weekly visiting,(which can occur off site in the community) twice weekly phone calls, visits from Probation Officers and Caseworkers. All residents stated they can call their attorneys. There is an MOU with the Crime Victims' Center to provide a Victim Advocate and emotional support. Posters have this contact information and there is a dedicated "button" on the phone to access this service. I spoke to a staff person from CVC prior to the on-site visit and they confirmed the services in the MOU and they were not aware of any incidents at the Boys' ITP. The facility has had no allegations of staff sexual harassment or sexual abuse in the past 12 months.

Prior to the on site visit during phone calls and emails, the PREA Coordinator and the Auditor discussed specific actions in regard to some policies and practices. Many of these were small additions to policy and were completed by the time of the visit and were provided to the Auditor at that time. Upon completion of the on-site portion of the Audit, an exit interview was conducted with the Associate Executive Director by phone, the COO/ PREA Coordinator, HR Director, Nursing Coordinator and the three PREA Managers, whose facilities were being audited. Three Standards were exceeded: # 331 Employee Training, #351, Resident Reporting and #383, Ongoing Medical and Mental Health Services. The following standards have not been met and require a corrective action plan: Due to the fact that an objective screening instrument pursuant to standard #341 had only recently been implemented, there was only one admission to review for timely administration as well as follow up pursuant to #342. Standard #333, Resident Education was implemented in March. Although the educational content and policy meet the standard, more admissions are needed to see that it is done in a timely fashion. There are limited openings (two) for this Unit and at this time no referrals for these beds. This policy is in

place and all staff have been trained. Other facilities under the agency umbrella have met this standard and I believe that the Boys' ITP will also follow the policy. At the end of an additional 60 day period or sooner if the beds are filled, documentation will be submitted for compliance with these standards. All other standards have been met and Agency Policy and Procedure comply with all PREA Standards.

On August 27, 2015, I received documentation of an admission to the Boys' ITP program, along with documentation of timely administration of the Vulnerability Assessment #341, follow up risk based housing decisions, #342 and timely resident education #333. Due to the fact that all facilities at Perseus are operating under the same policy, I feel that these practices have been institutionalized. All Standards have now been met and Agency Policy and Procedure comply with all PREA Standards.

Number of standards exceeded: 3

Number of standards met: 38

Number of standards not met: 0

Standard	**115.311 Zero Tolerance of Sexual Abuse and sexual harassment; PREA coordinator**

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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

A Zero tolerance Policy is in place and meets the standard. There is an agency wide PREA Coordinator, and a PREA Manager for this facility. Both appear on the organizational chart and both were interviewed and stated they have enough time for their PREA related duties.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ **xxx** 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

NA -Facility does not contract with other entities for confinement of residents

Standard	115.313 Supervision and Monitoring

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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 Boys ITP exceeds both the PREA mandated ratio as well as the Pa. DPW 3800 ratio. There were no deviations from the mandated ratio. Staffing is adjusted on a daily basis if needed to meet the needs of the population, including one on one supervision. Random unannounced rounds are performed by upper and middle level supervisors and logs of such were provided to me. There is a third shift supervisor responsible for conducting these rounds at all facilities and I interviewed him. I reviewed the most recent DPW inspection and there were no citations for not meeting ratio. Interviews of the PREA Coordinator/PREA Manager confirm compliance with all areas of this standard.

Standard	115.315 Limits to Cross Gender Viewing and Searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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 policy is in place and meets all areas of the standard. I interviewed random staff (9) and all residents (8). They confirm compliance with "knock and announce", which is posted at the entry to the second floor bedroom area. All residents shower alone. There are no hands-on searches conducted of any resident, except in exigent circumstances and then it is conducted with a nurse and one same sex staff. There were no cross-gender searches reported and most residents stated they have never been searched. A policy is in place, along with a cross-gender variant search form, for searches of Transgender or Intersex residents, although there were none. All staff interviewed could readily discuss this policy.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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

All postings were in both Spanish and English. All random staff interviewed (9) knew of the policy prohibiting the use of resident translators. There is a contract in place, which was reviewed by me during the on-site, for translation services. There were no residents with disabilities, nor non-English proficient children. Admission of these residents is on a case by case basis, but there are enough resources to provide for educational and emotional needs.

STANDARD 115.317 Hiring and Promotion Decisions

Exceeds Standard (substantially exceeds requirement of standard)

XXX 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 HR policy covers all areas of this standard and is also in compliance with the revised Pa. CPSL. An interview with the HR Director, confirmed compliance with this standard. She was unaware of the need to provide information as contained in #317 h. However, she is doing it for the Charter School component of the agency and will immediately start doing it for the residential side. I reviewed 12 staff files, including a newly hired staff and all contained the necessary documentation. Review off the facility's most recent DPW inspection did not show any citations for volunteers or staff.

STANDARD 115.318 Upgrades to Facilities and Technologies

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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 policy meets the standard. There have been no renovations or upgrades to the facility or technology.

STANDARD 115.321 Evidence and protocol and forensic medical examinations

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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 policy meets the standard. Administrative staff have completed an investigator training, but do NOT conduct investigations. Investigations are conducted by the City of Erie Police Dept. and there is an MOU. All forensic investigations are conducted at Hamot, in Erie and there is an MOU.

STANDARD 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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

Policy meets standard. All interviewed, Agency head, Director, PREA Coordinator, PREA manager, and Random staff (9) were well aware of the reporting mandate. There is a sexual abuse incident checklist.

STANDARD 115.331 Employee training

☐ **XXX** 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

A specialized curriculum was designed for Perseus house by a contracted trainer, with an extensive background in recognizing and treating those who have suffered sexual abuse. She trained all employees. Training logs and evaluations/sign off sheets were reviewed for 9 random staff and for those who also completed the investigator training. Additional PREA training was also conducted at weekly staff meetings at ITP by the PREA manager, who previously was the Clinician. These staff also received specialized sex offender training, above and beyond, because they work in this specialized Unit. All staff interviewed (9) had been trained and were able to demonstrate knowledge of their roles and responsibilities.

STANDARD 115.332 Volunteer and Contractor Training

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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

A policy is in place requiring an appropriate level of training for volunteers and contractors. I reviewed the information provided to them. There are no volunteers or contractors specific to this facility. I did interview a volunteer, by phone, who works at the Central Administration Building with all the residents. He confirmed receiving appropriate training and I did see a sign off that he did so. While on-site, I reviewed a binder of sign offs for any nonemployee/contractor who enters the premises.

STANDARD 115.333 Resident Education

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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 policy is in place. I have reviewed the video, and the information provided to the residents and it is appropriate. It is given at Intake, by the nurse, who I interviewed. All residents have received the education, and I saw sign off sheets in all 8 case files. All were able to respond to the interview questions, but because all but one resident had been admitted prior to PREA implementation, there were no examples of the timely education. Therefore, when the two vacancies are filled, documentation will be provided to me of timely education. However, if they are not filled within 60 days, this corrective action plan will be reviewed. Ongoing education, although provided by postings, is going to be enhanced by adding a PREA module to the 12 week Victim Awareness Curriculum. This information was provided to me. On August 27, 2015, I received documentation of an admission and timely education. This was the first Intake since March. Because this is policy and is being practiced in the other agency facilities, I feel that this documentation meets the standard.

STANDARD 115.334 Specialized Training: Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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 policy is in place and specifically details responsibilities. PREA Coordinators and Managers completed an on-line training for investigations and I saw a log and completion certificate for such. Any such investigations are designed only to gather information to turn over to the State Police and to develop safety plans to keep the residents safe. All investigations are completed by Child Line and the City of Erie Police Department. Administrative Investigations are conducted after the fact, so as not to interfere with an on-going investigations.

STANDARD 115.335 Specialized Training: Medical and mental health care.

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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

I saw the curriculum from the PRC. I saw the training logs and interviewed both the nurse and the Masters' Level Therapist, who confirmed having received the training and were able to outline their responsibilities.

STANDARD 115.341 Obtaining Information from residents

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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 policy is in place. The instrument that is used is objective and contains all necessary variables as outlined in the Standard. It is administered by the Nurse during Intake. An interview with the nurse confirms that she receives information from other sources including admissions packets to complete this assessment. All current residents had a risk assessment in their files, which were shown to me. Only one resident had it administered in a timely fashion because all others had been admitted prior to PREA implementation. There are two openings at the ITP. When they are filled, documentation of timely administration will be provided to me. This plan of correction will be reviewed if they are not filled within 60 days. This facility received an Intake during the last week of August. This was the first Intake since March. Documentation was provided to me of timely administration of the risk assessment. This is in practice at all other facilities under the agency umbrella and therefore, part of the culture and routine practice. This standard has been met.

STANDARD 115.342 Placement of Residents in housing, bed, program, education and work assignments

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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 policy is in place, as is the practice, however, there is no documentation of risk based housing decisions. All residents participate in education and programming together. They are admitted specifically to this placement. There are three bedrooms and the one closest to the staff desk, Dorm #1, can be used for a vulnerable child. All residents are identified as aggressive, because this is a sex offender program. When documentation of consideration of risk based housing decisions are provided to me, this standard will be met. Documentation of a risk based housing decision was provided to me on August 27, 2015, on the first Intake since March. It was done appropriately and in a timely fashion. This standard has been met.

STANDARD 115.351 Resident Reporting

☐ **XXX** 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

As mentioned in the narrative, every possible avenue for reporting has been provided to these residents and all are aware of them.

STANDARD 115.352 Exhaustion of Administrative Remedies

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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

An amended grievance policy was provided to me during the on-site and meets all the stipulations of the standard. Both residents and parents are provided with the grievance procedure during Intake and it is signed off on pursuant to the DPW regulations.

STANDARD 115.353 Resident Access to outside support services and legal representation

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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 an MOU in place with the Erie Crime Victims' Center (CVC). I spoke to a staff person there prior to the on-site to confirm those services. The brochure is posted and there is a dedicated button on a private phone for the residents. Staff (9) and residents (8) interviewed were familiar with these services. All residents stated they were able to phone their attorneys if they needed to. Interviews with Administrative staff confirm this as well.

STANDARD 115.354 Third Party Reporting

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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 policy meets the standard. Information is posted on the website and there are also postings in the area where the parents visit. Interviews with Administrators confirm compliance with this Standard, which also is mandated by the Pa. CPSL.

STANDARD 115.361 Staff and agency reporting duties

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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 information is contained in policy and is also part of the new employee orientation required by Pa. DPW 3800 regulations, regarding mandated reporters. All random staff (9) interviewed knew they were mandated reporters and must personally call Child Line as required in the revised Pa. CPSL. Administrators confirmed the Agency's role.

STANDARD 115.362 Agency protection duties

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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

All interviewed, Agency Head, Director, PREA Coordinator and Manager, as well as random staff (9) were well aware of the policy and their duty to protect a resident. Administration responded with several ways they could protect a resident from imminent sexual abuse, of which there were no reported incidents. ISOLATION is prohibited and never used.

STANDARD 115.363 Reporting to other confinement facilities

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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 is contained in the policy and also Pa. CPSL. An interview with the agency head confirms compliance with this policy, although there were no such incidents in the past 12 months.

STANDARD 115.364 Staff first Responder duties

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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 first responder duties are contained in the policy and listed in the employee training. All random staff interviewed (9) were able to discuss in detail their first responder responsibilities. There have been no allegations of sexual assault, so there were no staff who had to actually perform first responder duties.

STANDARD 115.365 Coordinated response

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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 coordinated response is in policy and there is also a sexual abuse incident checklist, so that staff can properly perform their duties. It is posted in the staff office. An interview with the Agency head confirms this response.

STANDARD 115.366 Preservation of ability to protect residents from contracts with abusers

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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 no Union or bargaining unit. The policy states that there are no obstacles to prevent protection of residents and this was confirmed in an interview with the Agency head.

STANDARD 115.367 Agency protection from retaliation

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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 policy meets standard. I interviewed both the HR Director, who is responsible for monitoring retaliation against employees and the PREA Manager who is responsible for monitoring retaliation of residents and also reporting retaliation against staff to the HR Director. Both knew what to look for to prevent and would monitor for at least 90 days or longer if needed. In the case of a resident, it could be as long as length of stay. Both would initiate contact with a staff or resident and have many resources to protect both staff and residents.

STANDARD 115.368 Post-allegation protective custody

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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 no use of isolation for post allegation protective custody or for any reason. This was confirmed during interviews with the Nurse, Mental Health Therapist, and PREA Coordinator, Manager and Agency Head. During the tour, I did not see any area where a child could be isolated.

STANDARD 115.371 Criminal and Administrative agency investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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

Whereas, the agency has administrators/PREA Coordinator/PREA Manager who have completed investigative training and I have seen the completion certificates and the curriculum, they do NOT complete any Criminal Investigations. They do limited Administrative investigations to ensure that policy and procedure are followed, so that everything can be turned over to the City of Erie P.D. and to Child Line. There is an MOU with Erie City PD. All subsections are in Policy, but are up to the Erie City PD and the District Attorneys' office. There is full cooperation with the City of Erie Police Department and an ongoing relationship that ensures that the Boys' ITP can be kept abreast of the investigation. Interview with the PREA Manager confirms this.

STANDARD 115.372 Evidentiary Standard for Administrative Investigations

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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 in policy.

STANDARD 115.373 Reporting to Residents

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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 is in policy and it meets the standard. An interview with the Assoc. Ex. Director and the CEO (by phone) confirms compliance. There were no children who had reported an incident to interview.

STANDARD 115.376 Disciplinary sanctions for staff

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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

Policy meets standard. There were no disciplinary actions to review.

STANDARD 115.377 Corrective Action for Contractors and Volunteers

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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

Policy meets standard. There were no incidents involving Contractors or Volunteers to review.

STANDARD 115.378 Interventions and Disciplinary sanctions for residents

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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

Policy meets standard and there were no residents to interview in this area and there were no incidents to review. I interviewed the CEO (by phone) Assoc. Ex. Director, the Nurse and the MH Therapist. Interviews confirmed compliance with this standard, including considering age, mental status, etc. on a case by case basis, consistent with other incidents.

STANDARD 115.381 Medical and Mental Health Screenings

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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 nurse administers the risk assessment as well as a Health and Safety Assessment during the Intake process. If a child identifies as having been previously sexually assaulted or being sexually aggressive, they are both offered Medical and Mental Health services. The Medical screen is done by the nurse immediately and the MH screen is done within 24 hours of Intake, by the Masters Level Therapist. I saw documentation of these timely services that are done for all residents, not just those identified in the resident files. I interviewed the nurse and a Masters' Level Mental Health Therapist, assigned only to this facility, who confirmed these practices. Residents interviewed (8) also confirm receiving these services in a timely manner.

STANDARD 115.382 Access to emergency medical and mental health services

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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

Policy meets standard. I interviewed the nurse and MH Therapist. There were no residents who had reported a sexual abuse to interview. There is a nurse present every day in the facility and on-call. The MH Therapist is also assigned to this unit and there are other resources available through the agency as well as MOUs with the Community resources.

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

☐ **XXX** 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 exceeds the standard. They are a treatment facility and residents are sent there by the Court to receive treatment. In addition to individual weekly therapy, there is group therapy, COG groups, and in many cases weekly family therapy in person or by phone. This is for all residents. The ITP program, because of its specialized nature, allows for the residents to receive more and intensive treatment.

STANDARD 115.386 Sexual Abuse Incident Reviews

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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

Policy meets standard. I interviewed the CEO who stated that they have a review process in place for all incidents and that as part of the Sanctuary model they use it on a regular basis. The incident review team would meet within 30 days of the completion of the investigation and would consider all variables noted in the standard. An interview with the PREA Manager at ITP, who is a member of the Incident Review Team confirmed compliance with this standard. There were no incidents to review.

STANDARD 115.387 Data Collection

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **Xxx** 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 is in compliance with this standard and the policy is in place. There was no data to review.

STANDARD 115.388 Data review for Corrective Action

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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

Policy meets standard. An interview with the PREA Coordinator/COO and the CEO indicate that data collection is something the agency does on an ongoing basis for any kind of incident. In compliance with this standard, the COO states that the first few reports would be compiled/written by the Admin team and subsequent reports would be written by the PREA Coordinator and approved by the COO for dissemination. Corrective action would be taken on an ongoing basis as needed.

STANDARD 115.389 Data storage, publication, and destruction

☐Exceeds Standard (substantially exceeds requirement of standard)

☐ **XXX** 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 PREA tab on the home page of the PERSEUS House website and the annual report as well as the Audit will be published on that site. Personal Identifiers will be redacted and that will be noted. All files will be retained or destroyed according to law.

AUDITOR CERTIFICATION:

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

Maureen G. Raquet *Sept. 2, 2015*

Certified PREA Auditor