

Prison Rape Elimination Act (PREA) Audit Report Juvenile Facilities

☐ Interim ☒ Final

Date of Interim Audit Report: Click or tap here to enter text. ☒ N/A

If no Interim Audit Report, select N/A

Date of Final Audit Report: October 2, 2020

Auditor Information

Name: Mable P. Wheeler **Email:** wheeler5p@hotmail.com

Company Name: M P Wheeler & Associates, LLC

Mailing Address: PO Box 5736 **City, State, Zip:** Macon, Georgia 31208

Telephone: 478-737-2171 **Date of Facility Visit:** July 30, 2020

Agency Information

Name of Agency: Alabama Department of Youth Services

Governing Authority or Parent Agency (If Applicable): Click or tap here to enter text.

Address: 1000 Industrial School Road **City, State, Zip:** Mt. Meigs, Alabama, 36057

Mailing Address: PO Box 66 **City, State, Zip:** Mt. Meigs, Alabama, 36057

The Agency Is: ☐ Military ☐ Private for Profit ☐ Private not for Profit

☐ Municipal ☐ County ☒ State ☐ Federal

Agency Website with PREA Information: <https://dys.alabama.gov/>

Agency Chief Executive Officer

Name: Lew Burdette

Email: lew@kingshome.com **Telephone:** 205-678-8331

Agency-Wide PREA Coordinator

Name: Katheria Edwards

Email: katheria@kingshome.com **Telephone:** 205-678-8331

PREA Coordinator Reports to: **Number of Compliance Managers who report to the PREA Coordinator:**
Jennifer Lackey 1

Facility Information

Name of Facility: King's Home DYS			
Physical Address: 63 AL Youth Drive		City, State, Zip: Westover, AL 35147	
Mailing Address: PO Box 162		City, State, Zip: Chelsea, AL 35043	
The Facility Is:	<input type="checkbox"/> Military	<input type="checkbox"/> Private for Profit	<input checked="" type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input type="checkbox"/> State	<input type="checkbox"/> Federal
Facility Website with PREA Information: kingshome.com			
Has the facility been accredited within the past 3 years? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years): <input type="checkbox"/> ACA <input type="checkbox"/> NCCHC <input type="checkbox"/> CALEA <input checked="" type="checkbox"/> Other (please name or describe: COA <input type="checkbox"/> N/A			
If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe: NA			
Facility Administrator/Superintendent/Director			
Name: Marcus Briggs			
Email: marcus@kinghome.com		Telephone: 205-678-6740	
Facility PREA Compliance Manager			
Name: Robby Allen			
Email: Robbie@kingshome.com		Telephone: 205-678-6740	
Facility Health Service Administrator <input checked="" type="checkbox"/> N/A			
Name:			
Email:		Telephone:	
Facility Characteristics			
Designated Facility Capacity:	12		
Current Population of Facility:	7		
Average daily population for the past 12 months:	6.67		
Has the facility been over capacity at any point in the past 12 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		

Which population(s) does the facility hold?	<input type="checkbox"/> Females <input checked="" type="checkbox"/> Males <input type="checkbox"/> Both Females and Males	
Age range of population:	12-20	
Average length of stay or time under supervision	92-120 days	
Facility security levels/resident custody levels	Low Level Offenders	
Number of residents admitted to facility during the past 12 months	21	
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:	21	
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:	21	
Does the audited facility hold residents for one or more other agencies (e.g. a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	<input type="checkbox"/> Federal Bureau of Prisons <input type="checkbox"/> U.S. Marshals Service <input type="checkbox"/> U.S. Immigration and Customs Enforcement <input type="checkbox"/> Bureau of Indian Affairs <input type="checkbox"/> U.S. Military branch <input checked="" type="checkbox"/> State or Territorial correctional agency <input type="checkbox"/> County correctional or detention agency <input type="checkbox"/> Judicial district correctional or detention facility <input type="checkbox"/> City or municipal correctional or detention facility (e.g. police lockup or city jail) <input type="checkbox"/> Private corrections or detention provider <input type="checkbox"/> Other (please name or describe): <input type="checkbox"/> N/A	
Number of staff currently employed by the facility who may have contact with residents:	12	
Number of staff hired by the facility during the past 12 months who may have contact with residents:	1	
Number of contracts in the past 12 months for services with contractors who may have contact with residents:	0	
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	0	
Number of volunteers who have contact with residents, currently authorized to enter the facility:	0	
Physical Plant		

Number of buildings: Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.	1
Number of resident housing units: Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.	1
Number of single resident cells, rooms, or other enclosures:	0
Number of multiple occupancy cells, rooms, or other enclosures:	5
Number of open bay/dorm housing units:	0
Number of segregation or isolation cells or rooms (for example, administrative, disciplinary, protective custody, etc.):	1
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Medical and Mental Health Services and Forensic Medical Exams	
Are medical services provided on-site?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Are mental health services provided on-site?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Where are sexual assault forensic medical exams provided? Select all that apply.	<input type="checkbox"/> On-site <input type="checkbox"/> Local hospital/clinic <input checked="" type="checkbox"/> Rape Crisis Center <input type="checkbox"/> Other (please name or describe):
Investigations	

Criminal Investigations		
Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:		0
When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.		<input type="checkbox"/> Facility investigators <input type="checkbox"/> Agency investigators <input checked="" type="checkbox"/> An external investigative entity
Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)	<input type="checkbox"/> Local police department <input checked="" type="checkbox"/> Local sheriff's department <input type="checkbox"/> State police <input type="checkbox"/> A U.S. Department of Justice component <input type="checkbox"/> Other (please name or describe): <input type="checkbox"/> N/A	
Administrative Investigations		
Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?		0
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: <i>Select all that apply</i>		<input type="checkbox"/> Facility investigators <input type="checkbox"/> Agency investigators <input checked="" type="checkbox"/> An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	<input type="checkbox"/> Local police department <input checked="" type="checkbox"/> Local sheriff's department <input type="checkbox"/> State police <input type="checkbox"/> A U.S. Department of Justice component <input type="checkbox"/> Other (please name or describe): <input type="checkbox"/> N/A	

Audit Findings

Audit Narrative (including Audit Methodology)

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

Introduction

The Prison Rape Elimination Act (PREA) audit onsite phase for King's Home was conducted September 2, 2020. King's Home is located at 63-AL Youth Drive, Westover, Alabama 35147. The audit was conducted by Mable P. Wheeler from Macon, Georgia, who is a U. S. Department of Justice Certified PREA auditor for juvenile facilities. The auditor conducted the audit as a single auditor with no additional support staff. The facility contacted the auditor regarding the audit and a contract was agreed upon and signed. There are no known existing conflicts of interest or barriers to completing the audit. The facility was last audited May 17, 2017, with 100% compliance with the PREA Juvenile Standards with 0 exceeds and 43 met standards and 0 standards no applicable to the program.

Mission:

King's Home seeks to serve and glorify God by providing Christ-centered homes and services in which compassion and competence combine to meet the needs of women, children and families.

Vision:

King's Home provides long-term, residential shelter, services, love, hope and opportunity for abused youth, moms and children in need. The program began in 1973 when "Bethany" Home was opened for homeless women. The King's Ranch for abandoned, neglected and abused youth was founded in 1976, and Hannah Home for abused women and children was opened in the 1980s. In 1998, Hannah Homes merged with The King's Ranch and is known today as King's Home, Inc. continuing to serve "at-risk" populations escaping domestic violence and other extreme and impoverished conditions and circumstances. In the spring of 2014, King's Home acquired Alabama Youth Homes. Now owning/operating 22 homes on six campuses in four Alabama Counties, King's Home continues with its mission and purpose to provide hope and healing to abused youth, women, and children.

Audit Methodology Pre-Onsite Audit Phase

Prior to being onsite, the PREA Compliance Manager and the auditor had discussions concerning access to the facility and staff, the audit process, logistics for the onsite phase of the audit, and goals and expectations. The PREA Compliance Manager was very receptive to the audit process and was well informed of the role of the auditor and the expectations during each stage of the PREA audit.

Notice of Audit Posting and Timeline

The audit notice was originally posted July 6, 2020. Due to COVID 19 the audit was postponed until September 2, 2020. The audit notice was posted in English on colorful paper using a large font. The audit notices were placed throughout the facility, in places visible to all residents, staff and visitors. Confirmation of audit notices was emailed to the auditor on July 6, 2020 for verification. Further verification of their placement was made through observations during the onsite review. The audit notices included a statement regarding confidentiality of resident and staff correspondence with the auditor. No correspondence was received during any phase of the audit.

Pre-Audit Questionnaire (PAQ) and Supporting Documentation

The PAQ and supporting documentation was received on March 18, 2020 the PAQ was completed fully with all necessary information. The documentation received on flash drive was well organized by standard. The auditor reviewed the PAQ, policy, procedures, and supporting documentation. Using the Auditor Compliance Tool and Checklist of Documentation, the auditor's initial analysis and review of the information determined it to be well organized with minimal omitted documentation.

Requests of Facility Lists

King's Home provided the following information for interview selections and document sampling:

Complete Resident Roster	An up-to-date roster was provided upon request. (several Staff interviews were conducted via Zoom)
Youthful inmates/detainees	
Residents with physical disabilities	None were identified.
Residents with cognitive disabilities	None were identified.
Residents who are Limited English Proficient	None were identified.
Lesbian, Gay, and Bisexual Residents	None were identified.
Transgender or Intersex Residents	None were identified.
Residents in segregated housing	None were identified.
Residents in isolation	None were identified.
Residents who reported sexual abuse	None were identified.
Residents who reported sexual victimization during risk screening	None were identified.
Complete Staff Roster	The staff roster and schedule were provided upon arrival to the facility.
Specialized Staff	Specialized staff was identified on the roster.
All contractors who have contact with the residents	1
All volunteers who have contact with the residents	0
All grievances/allegations of sexual abuse and sexual harassment made in the 12 months preceding the audit	0
All allegations of sexual abuse and sexual harassment reported for investigation in the 12 months preceding the audit	1
Detailed list of number of sexual abuse and sexual harassment allegations in the 12 months preceding the audit	1
All hotline calls made in the 12 months preceding the audit	0

External Contacts

The following external contacts were made:

Just Detention International	Just Detention International reviewed their database for records and information and reported no information for the preceding 12 months.
Community Based Organizations (CBOs) Children's Hospital Intervention and Prevention Services (CHIPS)	Child Advocacy Center (CAC): childrensal.org
Alabama Department of Youth Services	The auditor contacted the Alabama Department of Youth Services hotline at 855-332-1594.
Alabama Department of Youth Services	<ul style="list-style-type: none"> • PREA Coordinator at 334-215-3802 • Website

Research

Alabama Code 26-14-3 Mandatory reporting

(a) All hospitals, clinics, sanitariums, doctors, physicians, surgeons, medical examiners, coroners, dentists, osteopaths, optometrists, chiropractors, podiatrists, physical therapists, nurses, public and private K-12 employees, school teachers and officials, peace officers, law enforcement officials, pharmacists, social workers, day care workers or employees, mental health professionals, employees of public and private institutions of postsecondary and higher education, members of the clergy as defined in Rule 505 of the Alabama Rules of Evidence, or any other person called upon to render aid or medical assistance to any child, when the child is known or suspected to be a victim of child abuse or neglect, shall be required to report orally, either by telephone or direct communication immediately, and shall be followed by a written report, to a duly constituted authority.

(b)(1) When an initial report is made to a law enforcement official, the official subsequently shall inform the Department of Human Resources of the report so that the department can carry out its responsibility to provide protective services when deemed appropriate to the respective child or children.

(2) As soon as is practicable after a report of known or suspected child abuse or neglect is made, the Department of Human Resources shall make efforts to determine the military status of the parent or guardian of the child who is the subject of the child abuse or neglect allegation.

(3) If the Department of Human Resources determines that a parent or guardian under subdivision (2) is in the military, the department shall notify a United States Department of Defense family advocacy program at the military installation of the parent or guardian that there is an allegation of child abuse or neglect that is being investigated that involves a child of the military parent or guardian.

(c) When the Department of Human Resources receives initial reports of suspected abuse or neglect, as defined in Section 26-14-1, including suspected abuse or neglect involving discipline or corporal punishment committed in a public or private school or suspected abuse or neglect in a state-operated child residential facility, the Department of Human Resources shall transmit a copy of school reports to the law enforcement agency and residential facility reports to the law enforcement agency and the operating state agency which shall conduct the investigation. When the investigation is completed, a written report of the completed investigation shall contain the information required by the state Department of Human Resources which shall be submitted by the law enforcement agency or the state agency to the county department of human resources for entry into the state's central registry.

(d) Nothing in this chapter shall preclude interagency agreements between departments of human resources, law enforcement, and any other state agencies on procedures for investigating reports of suspected child abuse and neglect to provide for departments of human resources to assist law enforcement and other state agencies in these investigations.

(e) Any provision of this section to the contrary notwithstanding, if any agency or authority investigates any report pursuant to this section and the report does not result in a conviction, the agency or authority shall expunge any record of the information or report and any data developed from the record.

(f) Subsection (a) to the contrary notwithstanding, a member of the clergy shall not be required to report information gained solely in a confidential communication privileged pursuant to Rule 505 of the Alabama Rules of Evidence which communication shall continue to be privileged as provided by law.

(g) Commencing on August 1, 2013, a public or private employer who discharges, suspends, disciplines, or penalizes an employee solely for reporting suspected child abuse or neglect pursuant to this section shall be guilty of a Class C misdemeanor.

(Acts 1965, No. 563, p. 1049, §1; Acts 1967, No. 725, p. 1560; Acts 1975, No. 1124, p. 2213, §1; Acts 1993, 1st Ex. Sess., No. 93-890, p. 162, §3; Act 2003-272, p. 645, §1; Act 2013-201, p. 416, §1; Act 2016-354, §2; Act 2017-257, §1.)

Alabama Code 26-14-4 Permissive reporting

In addition to those persons, firms, corporations, and officials required by Section 26-14-3 to report child abuse and neglect, any person may make such a report if such person has reasonable cause to suspect that a child is being abused or neglected.
(Acts 1975, No. 1124, p. 2213, §1.)

Onsite Audit Phase

Entrance briefing

On September 2, 2020 the entrance briefing was held with the Assistant Program Director /PREA Compliance Manager and Program Counselor. Introductions were made and the agenda for the onsite audit was discussed. The audit was originally scheduled for two days, the small population of residents, size of the facility and the completion of several interviews conducted virtually due to (COVID 19 concerns). These factors enabled the auditor to complete the onsite portion of the audit in one day. After the entrance briefing the auditor began interviewing specialized staff and residents. During the site review, the auditor was accompanied by the PREA Compliance Manager.

Site review

The auditor had access to, and observed, all areas of the facility. The auditor was provided a diagram of the physical plant during the pre-onsite phase of the audit and was thus familiar with the layout of the facility. The facility consists of one (1) building which includes five (5) multiple occupancy rooms. The program designated capacity is 12 youth. The facility does not have a video monitoring system. Motion detectors located in the hallways alert staff of any movement out of the bedrooms.

Processes and areas observed

The auditor was able to observe the staff to resident ratios met the 1:8 requirement Auditor was unable to observe a demonstration of the intake and risk screening process. Two grievance boxes are located on the housing unit. Grievance forms and writing utensils are available upon request. One box is checked daily by facility staff and the other is checked monthly by DYS staff

The staff conducting the site review described the showering process, pointed out the location of the motion detectors. PREA posters with telephone numbers for reporting sexual abuse and sexual harassment are prominently placed in the housing and common area. The auditor informally asked residents about basic PREA information during visit to housing unit.

Specific area observations

The auditor observed the toilet and shower areas are out of view from staff. Resident rooms are multiple occupancy rooms. The auditor observed staff actively supervising the residents.

Exit briefing

An exit briefing was held with the Assistant Program Director and Program Counselor, to discuss audit findings. The auditor did have some areas of concern and requested additional supporting documentation.

The auditor requested additional supporting documentation including:

1. Assessment, checklist and Protocol for Behavior and Risk for Victimization - for all residents interviewed
2. Investigation report documentation for reported incident

Interviews Logistics

Location and Privacy

Some interviews were conducted via Zoom to comply with CDC guidelines during the COVID 19 pandemic. All interviews were voluntary and private. Onsite interviews were held in the staff office; this location provided privacy and was centrally located to minimize disruption of daily activities and programming. The auditor toured the site on September 2, 2020.

Selection Process

Eleven (11) specialized staff was selected based on their respective duties in the facility. Three (3) direct care staff were interviewed using the random staff interview protocol. This number represents all of the direct care staff employed by the facility. Six (6) residents were interviewed using the resident interview questionnaire. This number represents all six of the residents at the facility. There was one (1) resident identified for target interview. No (0) youth identified as transgender, no (0) youth identified as bisexual, and no (0) youth disclosed prior sexual victimization during risk screening. The resident population was six (6) on the onsite audit visit.

Interview Protocols	Number of Interviews
Administration and Agency Leadership	
Agency Head Designee (Agency PREA Coordinator)	1
Program Director	1
PREA Coordinator (DYS)	1
PREA Compliance Manager	1
Specialized Staff	
Medical Staff	1
Mental Health Staff	1
Non-Medical Staff Involved in Cross-Gender Strip Searches or Visual Body Cavity Searches (if applicable)	0 (such searches are prohibited)
Administrative (Human Resources) Staff	1
Agency Contract Administrator	1
Intermediate or Higher-level Facility Staff (unannounced rounds)	1
SAFE and SANE	0
Investigative Staff	1 Shelby County Sheriff's Department
Staff who Perform Screening for Risk of Victimization and Abusiveness	1
Staff who Supervise Residents in Isolation (no isolation)	0 (no isolation)
Staff on the Incident Review Team	1
Designated Staff Member Charged with Monitoring Retaliation	1
Security First Responders	0 (no security staff)
Non-Security Staff First Responders	1
Intake Staff	1
Random Sample of Staff	
First Shift	3
Second Shift	3
Total Random Sample of Staff	6
Volunteers Contractors who have Contact with Residents	
Volunteers	0
Contractors	0
Residents	
Random Sample of Residents from all Housing Units	6 (6 of 6 residents interviewed)
Targeted Resident Interviews	
Residents who Reported a Sexual Abuse	None identified
Residents with Cognitive Disabilities	None identified
Residents with Physical Disabilities	None identified
Limited English Proficient Residents	None identified
Gay, Lesbian, and Bisexual Residents	None identified
Transgendered and Intersex Residents	None identified
Residents who Disclosed Prior Sexual Victimization During Risk Screening	None identified
Residents in Isolation	None identified
Interview Totals	
Total Number of Staff Interviews	21
Total Number of Resident Interviews	6

Total Number of Interviews	27
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Interviewed Residents Length of Time at Facility

Days or Months	Number of Residents
1 Day to 31 Days	3
32 Days to 6 Months	2
7 Months to 12 Months	1
13 Months Plus	0

Records Review

Type of Record	Total Records Reviewed
Personnel Records/Documents	12
Volunteer and Contractors Files/Documents	0
Training Files/Documents/Records	12
Resident Files/Documents	6
Medical/Mental Health Records and Documentation for Victims	0
Grievance Forms (Sexual Abuse and Sexual Harassment)	0
All Incident Reports (Sexual Abuse and Sexual Harassment)	1
Investigation Records (Sexual Abuse and Sexual Harassment)	1

Investigative Files

Youth-on-Youth Sexual Victimization	Substantiated	Unsubstantiated	Unfounded
Nonconsensual Sexual Acts	0	0	0
Abusive Sexual Contact	0	0	0
Sexual Harassment	0	0	0
Staff-on-Youth Sexual Abuse	Substantiated	Unsubstantiated	Unfounded
Staff Sexual Misconduct	1 (under investigation)	0	0
Staff Sexual Harassment	0	0	0

Reporting Method	Sexual Abuse		Sexual Harassment	
	Youth-on-Youth	Staff-on-Youth	Youth-on-Youth	Staff-on-Youth
Hotline	0	0	0	0
Grievance	0	0	0	0
Verbal Report	1	0	0	0
Anonymous	0	0	0	0
Third Party	0	0	0	0
Reports by Staff	0	0	0	0

Facility Characteristics

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

Characteristics Related to PREA and Sexual Safety

Introduction	
Parent Agency	King's Home
Other Significant Relationship Information	Licensed by DYS
Facility Name	King's Home
Facility Address	63-AL Youth Drive, Westover, AL 35147

Age of Facility	14
Total Facility Rated Capacity	12
Resident Population Size and Makeup	
Average daily population in the last 12 months	6.67
Actual population on day 1 of the onsite portion of the audit	6
Population Gender	Male
Population Ethnicity	Multiethnic
Length of Stay	92 – 120 days
Staff Size and Makeup	
Number of Security Staff	0 (11 direct care staff) (1 PRN LPN)
Types of Supervision Practiced:	Direct Supervision
Number of Volunteers who may have contact with residents	0
Number of Contractors who may have contact with residents	0
Number of Interns who may have contact with residents	0
Number and Type of Housing Units	
Number of single-occupancy cells	0
Number of multiple-occupancy cells	5
Number of open-bay dorms	0
Number of segregation/isolation units	1
Number of medical units	0
Number of closed units	0
Type of Supervision (direct or indirect)	Direct
Video Monitoring	None (motion detectors)

Facility Operations

Physical Plant Description

The King's Home Group Home is housed in an attractive split- level home located in a residential area. The facility houses a maximum of 12 residents who are sent by court order to the facility by the Alabama Department of Youth Services.

The first floor of the facility houses the administration area composed of offices, a direct care staff office, with windows, enabling staff to observe activities in the den and down the few steps leading to several bedrooms. The den area serves as a dining room and day room. The kitchen is housed in a wide open area that can be viewed from a seat in the day room. . The facility has a sign on the pantry door restricting access to authorized staff only. Again, the kitchen can be viewed for the most part from the day room. Staff offices contain windows enabling viewing.

The restroom and showers on the first floor provide privacy. There are two shower stalls equipped with shower curtains. Staff related residents shower one youth at the time. There are two commodes in the restroom area, each separated by full wall stalls. A door leading to the basement is secured and accessible only to staff. It is recommended that a sign restricting access to authorized staff only is placed on this door as well and that this area is checked during unannounced PREA rounds, as well as other areas with solid doors.

The second floor contains a bath and shower enabling residents to shower and use the restroom individually behind a closed door. Upstairs bedrooms house double occupancy rooms and one dorm, designated as the "suite" houses "honor" residents who have earned the privilege of staying in this bedroom. This bedroom has its own bedroom, with a shower with curtains. Downstairs can be monitored by staff from the staff office which has a window facing the downstairs bedrooms. There are

several double occupancy rooms downstairs. One of the bedrooms has a door with a window enabling staff to monitor the bedrooms during routine checks without having to open the doors. The Mental Health Staffs office is located downstairs as well. There is no window in his door. A decision was made previously that in the absence of windows and cameras, a sign was placed on this door, to restrict access to Staff and Residents on Official Business Only. The Assistant Program Coordinator related that blind spots are mitigated by staff positioning themselves in strategic locations to activities in any given area.

The facility is replete with PREA Posters of all kinds and descriptions. These posters are graphically designed with bold "eye catching" colors. The Posters contain a wide variety of PREA related information. One huge poster has a megaphone with ways to report emanating from the megaphone. These included reporting verbally, through grievances, anonymously, through third parties and through ADAP (Alabama Disabilities Advocacy Program). Phone numbers and addresses of the following are posted for resident's viewing and reading. These included the following: 1) Children's Hope "CHIPS" Center; 2) ADAP. 3) Shelby Sheriff's Department; 4) Children's Hospital Emergency Room; and 5) The Department of Youth Services Sexual Assault 24 Hour Hotline; and 6) the Alabama Department of Homeland Security (for residents being held for civil immigration purposes only). Noteworthy is the fact that the facility posted information about the grievance process recommending that residents wanting to report sexual abuse or sexual harassment use the King's Home Grievance Process because the DYS Advocate who retrieves grievances may not retrieve the grievance until her next visit, which could be 1-2 weeks

Services Available

King's Home Basic Youth Program (Basic) serves a daily maximum of 8 boys (ages 10- 19) that are in custody of Alabama DYS. Per Alabama DYS, this basic type of placement is limited to children whose needs cannot be met in their own home, traditional foster home, or children who have reached their treatment goals in a more restrictive setting. The youth served by this program are low risk juvenile offenders with referral issues such as drug use, aggressive behaviors, truancy, and behavioral/emotional issues.

The program uses the Teaching Family Model (TFM) that originated at the University of Kansas; this model is listed as an evidence-based practice. The TFM model is one of the five most effective treatments for delinquent youth. The TFM model is considered a strengths-based program that can easily implement trauma informed care while teaching youth pro-social behaviors that will allow them to be successful young adults.

The TFM program is a strengths-based approach that seeks to identify strengths while recognizing praise is the strongest behavioral reinforcement. This program utilizes an individualized approach to design a behaviorally based Individualized Service Plan (ISP). The ISP intermittently reinforces the youth's strengths while identifying weaknesses and developing steps to improve these areas. The program primarily sees problem behaviors as a result of skills deficits. The program is designed to teach the youth appropriate social skills by learning pro-active alternative social skills through natural, daily, teaching interactions. These skills help the youth in their interaction with others, school performance, holding employment, and ensuring they have skills to be successful.

King's Home utilizes a Motivation System reinforcing positive behavior by motivating youth to reach their goals. The primary role of staff in the TFM is to focus on the youth's positive behavior and create a safe, effective learning environment. The program applies a behavioral treatment model that emphasizes skill teaching, positive relationships, and self-control. The model helps to further promote leadership/self-governance. This motivational system and behavioral program provides structure and consistency. Therapeutic Group Homes (TGH) can benefit youth as an alternative to a Youth Correction Center.

Summary of Audit Findings

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

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

Standards Exceeded

Number of Standards Exceeded: 0

List of Standards Exceeded:

Standard 115.317 Hiring and promotion decisions

Standards Met

Number of Standards Met: 43

Standards Not Met

Number of Standards Not Met: 0

List of Standards Not Met: [Click or tap here to enter text.](#)

PREVENTION PLANNING

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

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

115.311 (a)

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

115.311 (b)

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

115.311 (c)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.001 Protection from Sexual Abuse and Assault *(a)-1, p. 1, para. 1 *(a)-2, p. 1, para. 1
2. DYS Policy 13.8.1 Protection from Sexual Abuse and Assault
3. King's Home PREA Compliance Manager - Designation
4. King's Home Organizational Chart
5. Alabama DYS Organizational Structure
6. PREA Audit: Pre-Audit Questionnaire for King's Home

Interviews:

1. Agency PREA Coordinator
2. PREA Compliance Manager
3. Program Director

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.311 (a)

PAQ: The agency has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract. The facility has a policy outlining how it will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. The policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment. The policy includes sanctions for those found to have participated in prohibited behaviors. The policy includes a description of agency strategies and responses to reduce and prevent sexual abuse and sexual harassment of residents.

King's Home is committed zero-tolerance for all forms of sexual abuse assault/misconduct/harassment or rape with-in its congregate care facilities for children and youth and shall be committed to reducing the risk of sexual abuse, sexual harassment, assault, misconduct and rape through implementation of the Prison Rape Elimination Act (PREA) as outlined in Policy DYS-P.001 Protection from Sexual Abuse and Assault.

Policy provides guidelines for King's Home zero-tolerance for all forms of sexual abuse and sexual harassment, and the implementation of the Prison Rape Elimination Act (PREA) to provide a safe, humane and appropriately secure environment free from threat of sexual abuse/assault/misconduct/harassment or rape provided for all residents living in congregate care settings. DYS policy includes definitions of prohibited behaviors regarding sexual abuse and sexual harassment. The resident handbooks include inappropriate behaviors and resulting consequences.

King's Home policies addresses prevention of sexual abuse and sexual harassment through appropriate hiring and staffing of facilities, the designation of facility PREA Compliance Manager, staff supervision, identifying opportunities to separate and monitor sexually aggressive youth and potential victims, housing assignments, criminal background checks, staff training, resident education, PREA posters and educational materials, and creating a facility culture that discourages sexual aggression,

abuse and harassment. The policies address detection of sexual abuse and sexual harassment through resident education, providing protections for viewing and searches, staff training, and intake screening for risk of sexual victimization and abusiveness. The policies address responding to sexual abuse and sexual harassment through increasing awareness of safe reporting mechanisms and available services to victims, continuing education of staff and youth, investigations, disciplinary sanctions for residents and staff, victim advocates, access to emergency medical treatment and crisis intervention services, sexual abuse incident reviews, data collection, and data review for corrective action.

115.311 (b)

PAQ: The agency employs or designates an upper-level, agency-wide PREA Coordinator. The PREA Coordinator has sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards at the facility. The position of the PREA Coordinator is in the agency's organizational structure.

The PREA Coordinator for the Alabama Department of Youth Services is responsible for oversight and compliance with PREA standards in all adolescent residential facilities for children and youth. The PREA Coordinator confirmed she has sufficient time and authority to develop, implement and oversee agency efforts to comply with the PREA standards.

115.311 (c)

PAQ: The facility has designated a PREA Compliance Manager. The PREA Compliance Manager has sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards. The position of the PREA Compliance Manager is identified in the organizational chart. The PREA Compliance Manager reports to the Program Director of King's Home.

The PREA Compliance Managers will be responsible for coordination of their respective facility's efforts to comply with PREA standards. The PREA Compliance Manager will be responsible to report any violation of PREA standards to the agency PREA Coordinator. The PREA Compliance Manager confirmed he has sufficient time and authority to coordinate the facility's efforts to comply with the PREA Juvenile Standards.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor confirmed the agency and facility is fully compliant with this standard regarding zero tolerance of sexual abuse and sexual harassment and designation of an agency wide PREA Coordinator. No corrective action is required.

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

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

115.312 (a)

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

115.312 (b)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. Written Policies and Procedures 13.8.1 (a)-1 p. 1, 2
2. Contract with DYS
3. PREA Form 115.312 Contract Private Provider Receipt of PREA
4. King's Home Pre-Audit Questionnaire responses

Interviews:

Interview Agency PREA Coordinator
DYS Contract Manager

Findings (By Provision):

115.312 (a) & (b)

The Alabama Department of Youth Services (DYS) contracts for the confinement of its residents with the King's Home. DYS ensures that all contracted agencies are required to remain in compliance with PREA standards.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor confirmed the agency and facility is fully compliant with this standard regarding contracting with other entities for the confinement of residents. No corrective action is required.

Standard 115.313: Supervision and monitoring

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

115.313 (a)

- Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?
☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Generally accepted juvenile detention and correctional/secure residential practices? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any judicial findings of inadequacy? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from Federal investigative agencies? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from internal or external oversight bodies? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The number and placement of supervisory staff? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Institution programs occurring on a particular shift? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any applicable State or local laws, regulations, or standards? ☒ Yes ☐ No
- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No

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

115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? ☒ Yes ☐ No
- In circumstances where the staffing plan is not complied with, does the facility document all deviations from the plan? (N/A if no deviations from staffing plan.) ☐ Yes ☐ No ☒ NA

115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".) ☒ Yes ☐ No ☐ NA
- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".) ☒ Yes ☐ No ☐ NA
- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".) ☒ Yes ☐ No ☐ NA
- Does the facility ensure only security staff are included when calculating these ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of "secure".) ☒ Yes ☐ No ☐ NA
- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? ☒ Yes ☐ No

115.313 (d)

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

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

115.313 (e)

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA
- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA
- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. ADM-A.010 Leadership Rounds *(a)-1, p. 1, policy, paragraph 1
2. PREA Form 115.113 Supervisory Monitoring Log (e)-1, (e)-2, (e) -3, (e)-4
3. ADM-A.031 Ratio Coverage Staff to Patient *(e)-1, pp. 1-2, ss. A-C
4. DYS Policy 13.8.1 Protection from Sexual Abuse and Assault (a)-1 & (c)-1-3, p. 25-26, s. XVIII, subs. A&D (e)-1-4, p. 26, subs. XVIII, subs. B&CDYS
5. Policy DYS-P.001 Protection from Sexual Abuse and Assault
6. King's Home Pre-Audit Questionnaire responses
7. King's Home Staffing Plan
8. King's Home Annual Staffing Plan Assessments (2020)

Interviews:

1. Interview with the Program Director

2. Interview with the PREA Compliance Manager
3. Interview with Intermediate or Higher-Level Facility Staff

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):**115.313 (a)**

PAQ: Since the 2017 PREA audit:

1. The average daily number of residents: 6.56
2. The average daily number of residents on which the staffing plan was predicated: 12

The King's Home Staffing Plan states adequate care and supervision will be provided at all times to assure that each resident is safe and that his needs are met, in accordance with the resident's developmental level, age and emotional or behavioral problems.

The PREA Compliance Manager confirmed the facility regularly monitors staffing plan, maintains adequate staffing levels to protect residents against sexual abuse, considers monitoring as part of the plan, and documents the plan. When assessing staffing levels and needs the staffing plan considers: generally accepted juvenile detention and correctional/secure residential practices; any judicial findings of inadequacy; any findings of inadequacy from Federal investigative agencies; any findings of inadequacy from internal or external oversight bodies; all components of the facility's physical plant (including "blind spots" or areas where staff or residents may be isolated); the composition of the resident population; the number and placement of supervisory staff; institution programs occurring on a particular shift; any applicable State or local laws, regulations, or standards; the prevalence of substantiated and unsubstantiated incidents of sexual abuse; and any other relevant factors. The Program Director stated he monitors for compliance with the staffing plan to ensure staff are on duty.

The auditor reviewed the King's Home Staffing Plan for verification. The staffing plan is inclusive of the standard requirements.

115.313 (b)

PAQ: Should there be deviations from the staffing plan, the facility documents and justifies all deviations. However, the facility has never deviated from the facility staffing plan.

115.313 (c)

PAQ:

The facility is obligated by law, regulation, or judicial consent decree to maintain staffing ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours. The facility maintains staff ratios of a minimum of 1:8 during resident waking hours. The facility maintains staff ratios of a minimum of 1:16 during resident sleeping hours.

In the past 12 months:

1. The number of times the facility deviated from the staffing ratios of 1:8 security staff during resident waking hours: Zero (0)
2. The number of times the facility deviated from the staffing ratios of 1:16 security staff during resident sleeping hours: Zero (0)

Policy states each facility will maintain staff ratios of a minimum of 1:8 during resident wake hours and 1:16 during sleep hours. Compliance with the staffing plan is maintained by utilizing the PRN staff list. Should staff be unavailable, the on-call administrative staff will provide the additional needed staffing.

The Program Director confirmed King's Home is obligated by DYS and PREA Standards to maintain ratios of staff-to-youth ratios of 1:8 during resident wake hours and 1:16 during sleep hours. He ensures the facility maintains appropriate staffing ratios reviewing the staff schedule.

PREA Site Review: During the onsite tour of the facility the auditor observed the residents were being supervised within designated ratio, 1:8.

115.313 (d)

PAQ: At least once every year the agency or facility, in collaboration with the PREA Coordinator, reviews the staffing plan to see whether adjustments are needed to:

1. The staffing plan;
2. Prevailing staffing patterns;
3. The deployment of monitoring technology; or
4. The allocation of agency or facility resources to commit to the staffing plan to ensure compliance with the staffing plan.

Annually, the Program Director/PREA Compliance Manager in consultation with the PREA Coordinator will assess and document needed adjustments to staffing plans or patterns, and resources available to commit to ensure adherence to the staffing plan.

The PREA Compliance Manager confirmed that when assessing adequate staffing levels and the need for motion detectors, the assessment of the facility staffing plan considers all factors required by the standard. The auditor reviewed the King's Home Annual Staffing Plan Assessments for verification.

115.313 (e)

PAQ: The facility requires that intermediate-level or higher-level staff conducts unannounced rounds to identify and deter staff sexual abuse and sexual harassment. The facility documents unannounced rounds. The unannounced rounds cover all shifts. The facility prohibits staff from alerting other staff of the conduct of such rounds.

The Assistant Program Director/PREA Compliance Manager conducts unannounced rounds on all shifts on a regular basis and documents rounds. The purpose of the unannounced rounds is to ensure the safety of residents, the security of the facilities and deter any form of sexual abuse or sexual harassment. Staff is prohibited from alerting other staff members or staff at other facilities that unannounced rounds are occurring or may be occurring. Alerting other staff of unannounced rounds will result in disciplinary action. All unannounced rounds will be documented on Unannounced PREA Rounds form.

King's Home utilizes direct staff supervision to protect residents from sexual abuse and harassment. Administrative staff conducts and document unannounced rounds on all shifts for the maintenance of a safe environment. The unannounced rounds cover all shifts and all areas of the Facility. At least two unannounced rounds are conducted per month. Staff is prohibited from alerting other staff of such rounds. All unannounced rounds are documented using the Unannounced PREA Rounds form.

Corrective Action

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding supervision and monitoring. Corrective action is not required.

Standard 115.315: Limits to cross-gender viewing and searches

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

115.315 (a)

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

115.315 (b)

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

115.315 (c)

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

115.315 (d)

- Does the facility have policies that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No
- Does the facility have procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No
- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? ☐ Yes ☒ No
- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units) ☐ Yes ☐ No ☒ NA

115.315 (e)

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

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

115.315 (f)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.003 Searches *(a)-1, pp. 2,3,4 *(b)-1 single, closed-door showering*(e)-1, p. 6, sec. G4
2. DYS Policy 9.10 Searches
3. DYS Policy 13.8.1 Protection from Sexual Abuse and Assault
4. DYS Policy 13.14 Staff Conduct with DYS Juveniles of the Opposite Sex
5. King's Home Orientation for New Employees
6. King's Home Resident Handbook
7. Behavioral Health Center Pre-Audit Questionnaire responses
8. PREA Form 115.315 Cross-gender Strip Searches (c)-1
9. PREA Form 115.315 Cross-gender Visual Body Cavity Searches (c)-1
10. DYS Form 115.315 Cross Gender Pat-down Searches
11. Shift Duty Assignments

Interviews:

1. Interviews with a Random Sample of Staff
2. Interviews with a Random Sample of Residents

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):**115.315 (a)**

PAQ: The facility does not conduct cross-gender strip or cross-gender visual body cavity searches of residents.

In the past 12 months:

1. The number of cross-gender strip or cross-gender visual body cavity searches of residents: Zero (0)
2. The number of cross-gender strip or cross-gender visual body cavity searches of residents that did not involve exigent circumstances or were performed by non-medical staff: Zero (0)

King's Home does not conduct cross-gender strip or cross-gender visual body cavity searches of residents.

115.315 (b)

PAQ: The facility does not permit cross-gender pat-down searches of residents, absent exigent circumstances.

In the past 12 months:

1. The number of cross-gender pat-down searches of residents: Zero (0)
2. The number of cross-gender pat-down searches of residents that did not involve exigent circumstance(s): Zero (0)

115.315 (c)

PAQ: Facility policy requires that all cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches be documented and justified.

King's Home does not conduct cross-gender pat down, strip searches or visual body cavity searches.

115.315 (d)

PAQ:

The facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. Policies and procedures require staff of the opposite gender to announce their presence when entering a resident housing unit or area where residents are likely to be showering, performing bodily functions, or changing clothing.

Facility policies and procedures enable residents to shower, perform bodily functions, and change clothing without staff viewing their breasts, buttocks, or genitalia. The population is male, and all staff is male. All residents shower one at a time behind the privacy of a shower curtain and a closed bathroom door.

Resident interviews confirmed they are never naked in full view of staff of either gender. Staff interviews confirmed residents are able to dress, shower, and use the toilet without being viewed by staff of either gender.

PREA Site Review: Staff conducting the tour described the shower process. The residents shower individually behind the privacy of a closed bathroom door.

115.315 (e)

PAQ: The facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. Zero (0) such searches occurred in the past 12 months.

Staff members are prohibited from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status.

Staff interviewed confirmed they are aware policy prohibits them from searching or physically examining a transgender or intersex resident for the purpose of determining the resident's genital status.

115.315 (f)

PAQ: The percent of all security staff who received training on conducting cross-gender pat-down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs: 100%

Staff interviewed confirmed they have received such training regarding conducting searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs. Cross-gender pat-down searches do not occur.

Corrective Action

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding limits to cross-gender viewing and searches. No corrective action is required.

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

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

115.316 (a)

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

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have intellectual disabilities? ☒ Yes ☐ No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have psychiatric disabilities? ☒ Yes ☐ No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Residents who have speech disabilities? ☒ Yes ☐ No
- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (If "other," please explain in overall determination notes.) ☒ Yes ☐ No
- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No
- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? ☒ Yes ☐ No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? ☒ Yes ☐ No
- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

115.316 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? ☒ Yes ☐ No
- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

115.316 (c)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.001 Protection from Sexual Abuse and Assault*(a)-1 and (c)-1 pp. 5-6, s. A, subs. 4a-c *(c)-1, p. 1, policy, paragraphs 1-3
2. ADM-B.045 Plan for Access to Care for Limited English Proficient Patient
3. DYS Policy 13.8.1 Protection from Sexual Abuse and Assault (a)-1, p. 10, s. III, subs. D,1 (c)-1. P. 10, s. III, subs. D, 2
4. King's Home Pre-Audit Questionnaire responses
5. PREA Posters with Hotline Numbers for Outside Support Services (English and Spanish)
6. King's Home Resident Handbook (victim advocacy information)
7. Brochure: What you should know about sexual abuse & sexual assault (English and Spanish)

Interviews:

1. Interview with the PREA Coordinator
2. Interview with the Agency Head Designee
3. Interviews with Residents with Disabilities and Limited English Proficient Residents - N/A
4. Interviews with a Random Sample of Staff

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.316 (a)

PAQ: The agency has established procedures to provide disabled residents equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

King's Home ensures residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

The PREA Coordinator (DYS) confirmed King's Home has established procedures to provide residents with disabilities and residents who are limited English proficient equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. There were no residents (who are limited English proficient) who were identified during the onsite audit.

115.316 (b)

PAQ: The agency has established procedures to provide residents with limited English proficiency equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

The facility ensures meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient. The facility has interpreter services provided by Alabama Department of Youth Services. PREA brochures and PREA posters are available in Spanish and English. There were no residents identified as limited English proficient during the onsite audit.

115.316 (c)

PAQ: Agency policy prohibits use of resident interpreters, resident readers, or other types of resident assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the resident's safety, the performance of first-response duties under § 115.364, or the investigation of the resident's allegations.

1. The agency or facility documents the limited circumstances in individual cases where resident interpreters, readers, or other types of resident assistants are used.
2. In the past 12 months, the number of instances where resident interpreters, readers, or other types of resident assistants have been used and it was not the case that an extended delay in obtaining another interpreter could compromise the resident's safety, the performance of first-response duties under § 115.364, or the investigation of the resident's allegations: Zero (0)

Each facility will not rely on interpreters within the facilities, except in extreme circumstances where safety may be compromised. King's Home has a staff member who can provide translation for Spanish speaking residents in an emergency. The Alabama Department of Youth Services will provide interpreter services as needed.

Staff interviewed confirmed the agency does not use resident interpreters, resident readers, or other types of resident assistants to assist disabled residents or residents with limited English proficiency when making an allegation of sexual abuse or sexual harassment. Staff did not have knowledge of resident interpreters, resident readers, or other types of resident assistants being used in relation to allegations of sexual abuse or sexual harassment. There were no residents (who are limited English proficient) who were identified during the onsite audit.

Corrective Action

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding residents with disabilities and residents who are limited English proficient. It is also noted that youth are placed by DYS, and the placing authority is well aware of the services/limitations of each contract provider. No corrective action is required.

Standard 115.317: Hiring and promotion decisions

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

115.317 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No
- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No
- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

115.317 (b)

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

115.317 (c)

- Before hiring new employees, who may have contact with residents, does the agency perform a criminal background records check? ☒ Yes ☐ No
- Before hiring new employees, who may have contact with residents, does the agency consult any child abuse registry maintained by the State or locality in which the employee would work? ☒ Yes ☐ No
- Before hiring new employees who may have contact with residents, does the agency, consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? ☒ Yes ☐ No

115.317 (d)

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

115.317 (e)

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

115.317 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? ☒ Yes ☐ No
- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? ☒ Yes ☐ No
- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? ☒ Yes ☐ No

115.317 (g)

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

115.317 (h)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.010 Recruitment and Selection *(a)-1, pp. 1-2, para. 2 and (b)-1, p. 2, para. 2
2. HR I.013 (B) Employment Background Screening LOBHC *(e)-1, p. 2, paragraphs 3-4
3. Verification of Backgrounds completed on all staff.
4. Child Abuse Registry Checks (c)-1
5. Staff Interviews
6. DYS Form 115.317 PREA Employee Questionnaire (a)-1
7. King's Home Pre-Audit Questionnaire responses

Interview:

1. Interview with Administrative (Human Resources) Staff

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.317 (a)

PAQ: Agency policy prohibits hiring or promoting anyone who may have contact with residents, and prohibits enlisting the services of any contractor, who may have contact with residents, who:

1. Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997);
2. Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or

3. Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a) (2) of this section.

The facility does not hire or promote anyone who may have contact with residents, and does not enlist the services of any contractor who may have contact with residents, who has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse.

The auditor requested and was able to review personnel files and verified questions regarding previous misconduct for on each employee.

115.317 (b)

PAQ: Agency policy requires the consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

King's Home does not hire or promote anyone who has been found guilty of sexual harassment. The auditor observed employees are asked about previous accusations of sexual harassment as part of the questions regarding previous misconduct.

115.317 (c)

PAQ: Agency policy requires that before it hires any new employees who may have contact with residents, it (a) conducts criminal background record checks, (b) consults any child abuse registry maintained by the State or locality in which the employee would work; and (c) consistent with Federal, State, and local law, makes its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse

During the past 12 months:

1. The number of persons hired who may have contact with residents who have had criminal background record checks: 1
2. The percent of persons hired who may have contact with residents who have had criminal background record checks: 100%

Before hiring new employees, who may have contact with residents, the facility performs an extensive criminal background records check including: The National Sex Abuse Registry, Vulnerable Persons Abuse Registry, Drug Offence Registry, and the Alabama Department Youth Services Database. They contact prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse.

The facility Human Resources staff confirmed the facility performs criminal record background checks and considers pertinent civil or administrative adjudications for all newly hired employees who may have contact with residents and all employees, who may have contact with residents, who are being considered for promotions. Background checks are completed every five years for all employees.

The auditor reviewed questions regarding previous misconduct for verification.

115.317 (d)

PAQ: Agency policy requires that a criminal background records check be completed, and applicable child abuse registries consulted before enlisting the services of any contractor who may have contact with residents.

During the past 12 months:

1. The number of contracts for services where criminal background record checks were conducted on all staff covered in the contract who might have contact with residents: 0
2. The percent of contracts for services where criminal background record checks were conducted on all staff covered in the contract who might have contact with residents: N/A

Before hiring new employees, who may have contact with residents, the facility performs an extensive criminal background records check including: The National Sex Abuse Registry/FBI, Child Abuse Registry for Alabama.

The facility Human Resources staff confirmed the facility performs criminal record background checks and considers pertinent civil or administrative adjudications before enlisting the services of any contractor who may have contact with residents.

115.317 (e)

PAQ: Agency policy requires that either criminal background records checks be conducted at least every five years of current employees and contractors who may have contact with residents or that a system is in place for otherwise capturing such information for current employees.

The auditor reviewed criminal background record checks of current employees for verification they are being conducted every five years.

115.317 (f)

King's Home asks applicants about the disqualifications for employment via the PREA Employment Questionnaire at hire, for promotions, and annually during evaluations.

The facility Human Resources staff confirmed the facility asks all applicants and employees who may have contact with residents about previous misconduct described in section (a)* in written applications for hiring or promotions, and in any interviews or written self-evaluations conducted as part of reviews of current employees.

These questions are asked during the hiring process, for promotions and during annual evaluations. The auditor reviewed questions regarding previous misconduct for new hires, promotions, and evaluations for verification.

115.317 (g)

PAQ: Agency policy states that material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

Employees have a continuing affirmative duty to disclose any such misconduct and material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

The auditor observed employees verify they understand that omissions regarding previous misconduct, or providing false information, shall be grounds for termination. This verification is included with the questions regarding previous misconduct.

115.317 (h)

The facility Human Resources staff confirmed when a former employee applies to work at another institution, upon request from that institution, King's Home can state whether the employee was terminated and whether they would be considered for re-hire.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility meets this standard regarding hiring and promotion decisions. . No corrective action is required.

Standard 115.318: Upgrades to facilities and technologies**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report****115.318 (a)**

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

115.318 (b)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

The narrative below must include a comprehensive discussion of all the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.001 Protection from Sexual Abuse and Assault *(b)-1, p. 15, s. J, subss. 1 and 3
2. Written Policy and Procedures 13.8.1 (a)-1, p.29, s. XXIV, subss. A-B
3. King's Home Pre-Audit Questionnaire responses

Interviews:

1. Interview with the PREA Compliance Manager
2. Interview with the Program Director

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.318 (a)

PAQ: The agency or facility has not acquired a new facility or made a substantial expansion or modification to existing facilities since the last PREA audit.

The PREA Manager and Program Director both confirmed the facility would consider the ability to protect residents from sexual abuse when designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities. Also, the agency would consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse.

115.318 (b)

PAQ: The agency or facility has not installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology since the last PREA audit.

The PREA Manager and Program Director both confirmed when installing or updating the motion monitoring system, or other monitoring technology, the agency shall consider how such technology may enhance the agency's ability to protect residents from sexual abuse.

PREA Site Review:

The auditor observed there were no expansions or modifications to the facility since the last PREA audit.

Corrective Action

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding upgrades to facilities and technology. No corrective action is required.

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

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

115.321 (a)

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

115.321 (b)

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

115.321 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiary or medically appropriate? ☒ Yes ☐ No
- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No
- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? ☒ Yes ☐ No
- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

115.321 (d)

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

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member? (N/A if the agency *always* makes a victim advocate from a rape crisis center available to victims.) ☒ Yes ☐ No ☐ NA
- Has the agency documented its efforts to secure services from rape crisis centers? ☒ Yes ☐ No

115.321 (e)

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

115.321 (f)

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

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.001 Protection from Sexual Abuse and Assault * (C)-2, p. 12, s. H, subs. D Uniform Evidence Protocol
2. DYS Policy 13.8.1 Protection from Sexual Abuse and Assault
3. National Protocol For Sexual Assault
4. Letter of Agreement with Local Law Enforcement for Criminal Investigations (f) -1
5. Supporting Documentation:
6. PREA Form 115.321 Victim Advocate Receipt of PREA
7. PREA Form 115.321.1 PREA Confidentiality and the DYS Victim Advocate
8. CHIPS Center (Children's Hospital Intervention and Prevention Services) (MOU)
9. Letter of Agreement with the Shelby County Sheriff's Department

Interviews:

1. Interview with the PREA Compliance Manager
2. Interviews with a Random Sample of Staff
3. Interviews with Residents who Reported a Sexual Abuse – N/A
- 4.

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.321 (a)

PAQ: King's Home is not responsible for conducting administrative or criminal sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct).

Administrative and criminal sexual abuse and sexual harassment investigations for King's Home are conducted by the Shelby County Sheriff's Department. All forensics are completed by a local hospital (CHIPS) or the Rape Crisis Center. This service is provided at no cost to residents as outlined by policy. There have been no forensic examinations in the last 12 months. When a sexual assault forensic examiner or a sexual assault nurse examiner is not available, a qualified medical practitioner will perform the forensic examination. CHIPS Center (Children's Hospital Intervention and Prevention Services) coordinates all services required by a youth after an incident. There are qualified staff members at the facility that can provide crisis intervention if requested by the resident in addition to outside providers. A youth may elect to refuse medical treatment after an incident of sexual abuse/assault. The Shelby County Sheriff's Department currently has an active sexual assault (resident on resident) investigation in progress from King's Home.

115.321 (b)

The uniform evidence protocol is developmentally appropriate for youth. The protocol was adapted from or otherwise based on the most recent edition of the DOJ's Office on Violence Against Women publication, 'A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents,' or similarly comprehensive and authoritative protocols developed after 2011.

DYS adheres to the National Protocol for Sexual Assault Medical Forensic Examinations for Adults and Adolescents.

115.321 (c)

PAQ: The facility offers all residents who experience sexual abuse access to forensic medical examinations. Forensic medical examinations are offered without financial cost to the victim. Where possible, examinations are conducted by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs). When SANEs or SAFEs are not available, a qualified medical practitioner performs forensic medical examinations.

During the past 12 months:

1. The number of forensic medical exams conducted: Zero (0)
2. The number of exams performed by SANEs/SAFEs: Zero (0)
3. The number of exams performed by a qualified medical practitioner: Zero (0)

For those sexual abuse incidence alleged to have occurred within seventy two (72) hours, staff will offer to take the child/youth to the local emergency room for examination, collection and preservation of evidence, and treatment (without financial cost to the resident). Staff will request that the examination be performed by Sexual Assault Forensic Examiners (SAFEs's) or Sexual Assault Nurse Examiners (SANE's) if possible. If SAFE's or SANE's cannot be made available, the examination can be performed by other qualified medical professionals at a local hospital. CHIPS Center (Children's Hospital Intervention and Prevention Services) will provide a certified SANE Nurse. The incident currently under investigation was reported well beyond the seventy- two (72) hours timeframe. A forensic exam was not conducted.

115.321 (d)

PAQ: The facility makes a victim advocate from a rape crisis center available to the victim, in person or by other means. These efforts are documented. If and when a rape crisis center is not available to provide victim advocate services, the facility provides a qualified staff member from a community-based organization or a qualified agency staff member.

King's Home has a MOU with the CHIPS Center (Children's Hospital Intervention and Prevention Services). The auditor confirmed availability of the services through telephone correspondence and reviewing the MOU Agreement. These services are available weekdays during normal business hours. Afterhours and on weekends, King's Home has staff that can accompany and support victims through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals.

The Facility PREA Compliance Manager confirmed a qualified victim advocate from the CHIPS Center (Children's Hospital Intervention and Prevention Services) would provide emotional support, crisis intervention, information, and referrals during the forensic medical examination process and investigatory interviews.

115.321 (e)

PAQ: If requested by the victim, a victim advocate, or qualified agency staff member, or qualified community-based organization staff member accompanies and supports the victim through the forensic medical examination process and investigatory interviews and provides emotional support, crisis intervention, information, and referrals.

King's Home has a MOU with the CHIPS Center (Children's Hospital Intervention and Prevention Services). The auditor confirmed availability of the services through telephone correspondence and

reviewing the MOU. These services are available weekdays during normal business hours. Afterhours and on weekend's examinations would be conducted at the Children's Hospital of Alabama, an advocate from the local Rape Crisis Center would accompany and support victims through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals.

The Facility PREA Compliance Manager confirmed a qualified victim advocate from the CHIPS Center (Children's Hospital Intervention and Prevention Services) who would provide emotional support, crisis intervention, information, and referrals during the forensic medical examination process and investigatory interviews.

115.321 (f)

PAQ: The agency is not responsible for administrative or criminal investigating allegations of sexual abuse and relies on another agency to conduct these investigations. The agency has requested that the responsible agency follow the requirements of paragraphs §115.321 (a) through (e) of the standards.

The Shelby County Sheriff's Department is responsible for administrative or criminal investigating allegations of sexual abuse. The CHIPS Center (Children's Hospital Intervention and Prevention Services) (CAC) has a Cooperative Agreement with the Shelby County Sheriff's Department for criminal referrals. The auditor reviewed the agreement with the police depart and advocacy center for verification.

Corrective Action

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding evidence protocol and forensic medical examinations. No corrective action is required.

Standard 115.322: Policies to ensure referrals of allegations for investigations

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

115.322 (a)

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

115.322 (b)

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

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

115.322 (c)

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

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. Policy and Procedures 13.8.1 (a)-1, (b)-1, pp. 19-21, s. XIII, subss. 1-16
2. PREA Form 115.371 Process for Investigating Sexual Assaults
3. King's Home Pre-Audit Questionnaire responses

Interviews:

1. Interview with the Agency Head Designee (Agency Wide PREA Coordinator)
2. PREA Compliance Manager
3. Shelby County Sheriff's Department Staff

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):**115.322 (a)**

PAQ: The agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.

In the past 12 months:

1. The number of allegations of sexual abuse and sexual harassment that were received: One (1)
2. The number of allegations resulting in an administrative investigation: Zero (0)
3. The number of allegations referred for criminal investigation: One (1)
4. Referring to allegation received in the past 12 months, administrative and/or criminal investigation is currently pending.

King's Home ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse, sexual assault, sexual misconduct, and sexual harassment. All incidents are documented.

The Agency Head Designee (Agency Wide PREA Coordinator) confirmed that an administrative or criminal investigation is completed for all allegations of sexual abuse or harassment. She stated the local Shelby County Sheriff's Department is responsible for all investigations administrative and criminal investigations. The facility does not conduct administrative or criminal investigations.

115.322 (b)

The agency's policy regarding the referral of allegations of sexual abuse or sexual harassment for a criminal investigation is published on the agency website at:

<https://dys.alabama.gov/prea>

PAQ: The agency has a policy that requires that allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations, including the agency if it conducts its own investigations, unless the allegation does not involve potentially criminal behavior. The agency's policy regarding the referral of allegations of sexual abuse or sexual harassment for a criminal investigation is published on the agency website. The agency documents all referrals of allegations of sexual abuse or sexual harassment for criminal investigation.

The agency's policy regarding the referral of allegations of sexual abuse or sexual harassment for a criminal investigation is published on the agency website at:

<https://dys.alabama.gov/prea>

115.322 (c)

King's Home PREA Policy describes the responsibilities of the King's Home, Shelby County Sheriff's Department and DYS.

The auditor reviewed the published policy and verified the policy describes investigative responsibilities of both the Agency and King's Home.

115.322 (d)

Any State entity responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations.

There is no Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment.

115.322 (e)

Any Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment in juvenile facilities shall have in place a policy governing the conduct of such investigations.

There is no Department of Justice component responsible for conducting administrative or criminal investigations of sexual abuse or sexual harassment.

Corrective Action

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding policies to ensure referrals of allegations for investigations. No corrective action is required.

TRAINING AND EDUCATION

Standard 115.331: Employee training

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

115.331 (a)

- Does the agency train all employees who may have contact with residents on its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on residents' right to be free from sexual abuse and sexual harassment ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on the right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on the dynamics of sexual abuse and sexual harassment in juvenile facilities? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on the common reactions of juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on how to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to avoid inappropriate relationships with residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on relevant laws regarding the applicable age of consent? ☒ Yes ☐ No

115.331 (b)

- Is such training tailored to the unique needs and attributes of residents of juvenile facilities? ☒ Yes ☐ No
- Is such training tailored to the gender of the residents at the employee's facility? ☒ Yes ☐ No
- Have employees received additional training if reassigned from a facility that houses only male residents to a facility that houses only female residents, or vice versa? ☒ Yes ☐ No

115.331 (c)

- Have all current employees who may have contact with residents received such training? ☒ Yes ☐ No
- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No
- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

115.331 (d)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. King's Home Staff Development Plan
2. DYS-P 002 Sexual Abuse Assault Harassment Training *(a)-1 pp. 1-2, s. A, subss. a-k
3. DYS Policy 13.16 Child Abuse Reporting
4. DYS Policy 13.8.1 Protection from Sexual Abuse and Assault (a)-1, pp. 4-5, s. I, subss. A, 1-4
5. Code of Alabama 1975 Section 26-14-3
6. Proposed Employee Training Curriculum
7. DYS Form 115.331 Staff Confirmation of receipt of PREA
8. DYS Pamphlet 115.331 What Staff Should Know About Sexual Misconduct with Juveniles
9. Staff Annual Training Record

Interviews:

1. Interviews with a Random Sample of Staff

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.331 (a)

PAQ: The agency trains all employees who may have contact with residents on the eleven (11) required topics.

All staff assigned to work in adolescent residential facilities will receive training in compliance with PREA standards.

The training curriculum includes the following topics:

(1) Its zero-tolerance policy for sexual abuse and sexual harassment; (2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; (3) Residents' right to be free from sexual abuse and sexual

harassment; (4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment; (5) The dynamics of sexual abuse and sexual harassment in juvenile facilities; (6) The common reactions of juvenile victims of sexual abuse and sexual harassment; (7) How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents; (8) How to avoid inappropriate relationships with residents; (9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; (10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities; and (11) Relevant laws regarding the applicable age of consent.

Staff interviewed confirmed they have received training on the eleven (11) PREA topics in standard 115.331 when hired and PREA refresher training annually. The auditor reviewed staff training records for verification.

115.331 (b)

PAQ: Training is tailored to the unique needs and attributes and gender of the residents at the facility. Employees who are reassigned from facilities housing the opposite gender are given additional training.

The auditor reviewed the PREA training curricula/PowerPoints for verification.

115.331 (c)

PAQ: The number of staff currently employed by the facility, who may have contact with residents, who were trained or retrained on PREA requirements: 12

The percent of staff currently employed by the facility that may have contact with residents, who were trained or retrained on PREA requirements: 100%

The agency PREA refresher training will be conducted once a year. All full and part-time staff members are required to complete the refresher training. The auditor reviewed the PREA training and staff training records for verification.

115.331 (d)

PAQ: The agency documents that employees who may have contact with residents understand the training they have received through employee signature or electronic verification.

Policy states the facility will document, through employee signature or electronic verification that the employees understand the training they have received. Staff must complete all PREA modules with an 80% passing rate. Staff signs the Prison Rape Elimination Act (PREA) Acknowledgement and their participation is electronically recorded in the Staff Training Hours Report.

Corrective Action

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility meets this standard regarding employee training. Employees are trained annually. No corrective action is required.

Standard 115.332: Volunteer and contractor training

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

115.332 (a)

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

115.332 (b)

- Have all volunteers and contractors who have contact with residents been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents (the level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents)? ☒ Yes ☐ No

115.332 (c)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P 002 Sexual Abuse Assault Harassment Training *(a)-1 pp. 3-4, s. D, subss. 1-3
2. DYS Policy 4.3.1 Sexual Abuse/Assault/Harassment Training
3. DYS Policy 13.8.1 Protection from Sexual Abuse and Assault *(a)-1, pp. 6-7, s. I, subs. E,1-4
4. Volunteer and Contractor Training Curriculum *(a)-1, p. 6
5. DYS Form 115.332 Volunteer and Contractor Receipt of PREA
6. DYS Form 115.311 PREA Fact Sheet

Interviews:

1. Interview with PREA Compliance Manager
2. Interview with Program Director
3. Human Resources
4. Contract LPN

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):**115.332 (a)**

PAQ: All volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response.

1. The number of volunteers and contractors, who have contact with residents, who have been trained in agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response: 1
2. The percent of volunteers and contractors, who have contact with residents, who have been trained in agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response: 100%

All volunteers and contractors assigned to work in adolescent residential facilities will receive training in compliance with PREA standards. King's Home has no active volunteers.

115.332 (b)

PAQ: The level and type of training provided to volunteers and contractors shall be based on the services they provide and level of contact they have with residents, but all volunteers and contractors who have contact with residents shall be notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

King's Home has one active contractor. The auditor reviewed contractor acknowledgement form for verification. Volunteers and contractors are notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

115.332 (c)

PAQ: The agency maintains documentation confirming that volunteers and contractors understand the training they have received.

Volunteers' sign Employee Acknowledgement and Notification of Prison Rape Elimination Act (PREA) to acknowledge they have read the DYS zero-tolerance policy and understand the training they have received.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding volunteer and contractor training. The facility currently has zero volunteers and one contractor permitted on site. No corrective action is required.

Standard 115.333: Resident education**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report****115.333 (a)**

- During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment? ☒ Yes ☐ No
- During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment? ☒ Yes ☐ No
- Is this information presented in an age-appropriate fashion? ☒ Yes ☐ No

115.333 (b)

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

115.333 (c)

- Have all residents received the comprehensive education referenced in 115.333(b)?
☒ Yes ☐ No
- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility?
☒ Yes ☐ No

115.333 (d)

- Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Are deaf? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled? ☒ Yes ☐ No
- Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills? ☒ Yes ☐ No

115.333 (e)

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

115.333 (f)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.005 Reception and Orientation *(a)-1 pp. 3-4, s. 16
2. DYS Policy 13.8.1 Protection from Sexual Abuse and Assault *(c)-3, pp. 9-10, s. III, subss. A-G *(d)-1, p. 10, s. III, subss. D, 1-2
3. DYS Policy 17.1 Reception and Orientation *(d)-1, p. 5, s. III, subs. 16, g (limited English proficient, deaf, visually impaired, otherwise disabled and limited reading skills)
4. Juvenile Handbook Orientation on Sexual Assault
5. DYS Pamphlet 115.333 What You Should Know About Sexual Abuse and Assault
6. DYS Form 115.333.1 Juvenile Receipt of PREA
7. DYS Form 115.333.2 DYS Youth Safety Guide
8. DYS Power Point Presentation 115.333 Sexual Assault in the Juvenile Corrections Setting
9. DYS Power Point Presentation 115.333.1 PREA Facts Every Juvenile Should Know
10. PREA Pamphlet 115.333LF *(d)-1 (limited reading skills)
11. PREA Pamphlet 115.333S *(d)-1 (limited English proficient- Spanish)
12. Access to Interpreters *(d)-1 (limited English proficient, deaf, visually impaired, otherwise disabled and limited reading skills)

Interviews:

1. Interview with Program Counselor
2. Interviews with Residents

Site Review Observations:

Observations during on-site review of physical plant Posters and other Visual Aides.

Findings (By Provision):**115.333 (a)**

PAQ: Residents receive information at time of intake about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. This information is provided in an age appropriate fashion.

Of residents admitted during the past 12 months:

1. The number who were given this information at intake: 21
2. The percent who were given this information at intake: 100%

During the intake process, each resident will receive information explaining, in an age and developmentally appropriate fashion; the agency's zero tolerance policy regarding sexual abuse/assault/misconduct/harassment and how to report incidence or suspicions of sexual abuse or sexual harassment. Written and verbal information on PREA will be provided and explained to each resident within (24) twenty-four hours of arrival at the facility.

The Intake Staff/Program Counselor confirmed residents are educated on the facility's zero-tolerance policy on sexual abuse and sexual harassment and how to report during intake. Written and verbal information on PREA is provided and explained to all residents within 24 hours of intake. Residents interviewed confirmed they were informed of their right not to be sexually abused and sexually harassed, how to report, and their right not to be punished for reporting, during the intake process. They confirmed they received information about the facility's rules against sexual abuse and harassment through training materials, pamphlets, and resident handbooks.

The auditor reviewed intake records of residents entering the facility in the past 12 months and residents interviewed for verification. This information is documented with the Training of Residents for Emergency Procedures and Orientation form.

115.333 (b)

PAQ: Of residents admitted during the past 12 months:

1. The number who received such education within 10 days of intake: 21
2. The percent who were given this information within 10 days of intake: 100%

Within the initial 10 days of placement, residents will receive a more comprehensive training on PREA. Completion of this training will be documented on the Training of Residents for Emergency Procedures and Orientation form filed in each resident's case file.

The Intake Staff/Program Counselor confirmed the facility ensures that residents are educated regarding their rights to be free from sexual abuse and sexual harassment, and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents by providing the information in various educational formats and requiring the residents to sign an acknowledgment form stating they understand the information. He confirmed residents are made aware of these rights within 24 hours after intake. Residents interviewed confirmed they were informed of their right not to be sexually abused and sexually harassed, how to report, and their right not to be punished for reporting, during the intake process. Residents stated they received the information on their first or second day at the facility. They also confirmed they received information about the facility's rules against sexual abuse and harassment.

Within 72 hours of admission, the facility provides comprehensive age-appropriate orientation to youth, with the staff advising youth of the right to be free from sexual abuse, sexual harassment, and retaliation for reporting such incidents, and regarding Agency policies and procedures for responding to such incidents. The Agency provides resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills. Residents are provided a handout. Documentation of residents signatures were reviewed and confirmed during resident interviews. All residents must sign DYS Form 115.333.1 Juvenile Receipt of PREA.

Posters are located throughout the Facility. They provide important contact information for the Alabama DYS Sexual Assault hotline and victim advocate services. The auditor reviewed intake records of residents entering the facility in the past 12 months and residents interviewed for verification. This information is documented with Juvenile Confirmation of Receipt Prison Rape Elimination Act (PREA). The auditor also reviewed relevant educational materials including posters, resident handbooks, pamphlets, and the PREA Comprehensive Education Curriculum.

115.333 (c)

PAQ: All residents were educated within 10 days of intake.

Within the initial 10 days of placement, residents will receive a more comprehension training on PREA. Completion of this training will be documented on the Training of Residents for Emergency Procedures and Orientation form filed in each resident's case file.

The Intake Staff/Program Counselor confirmed all residents are educated on the facility's zero-tolerance policy on sexual abuse and sexual harassment regardless if they are transferred from other facilities.

The auditor reviewed intake records of residents entering the facility in the past 12 months and residents interviewed for verification.

115.333 (d)

PAQ: The agency shall provide resident education in formats accessible to all residents, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to residents who have limited reading skills.

Appropriate provisions are made as necessary for residents who are of limited English proficiency, have disabilities (including those who are deaf or hard of hearing, those who are blind or have low vision), and those with psychiatric, speech or reading disabilities. Limited English proficient residents will be provided with an interpreter for assessments and to provide educational materials. King's Home does not rely on resident interpreters for PREA information and education. If an interpreter is needed, the facility contacts the Alabama Department of Youth Services who will provide an interpreter.

115.333 (e)

PAQ: The agency maintains documentation of resident participation in PREA education sessions.

Policy states all residents are required to sign DYS form CS-0939, Youth Acknowledgment and Notification of Prison Rape Elimination Act (PREA) and the Training of Residents for Emergency Procedures and Orientation form.

The auditor reviewed youth acknowledgment forms of residents entering the facility in the past 12 months and residents interviewed for verification.

115.333 (f)

PAQ: The agency ensures that key information about the agency's PREA policies is continuously and readily available or visible through posters, resident handbooks, or other written formats.

The auditor reviewed the resident handbook, pamphlets, and other educational materials available in English and Spanish. During the site review the auditor observed PREA posters are placed prominently in areas of the facility that are easily accessible by the residents.

Corrective Action

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding resident education. No corrective action is required.

Standard 115.334: Specialized training: Investigations

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

115.334 (a)

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

115.334 (b)

- Does this specialized training include techniques for interviewing juvenile sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☐ Yes ☐ No ☒ NA
- Does this specialized training include proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☐ Yes ☐ No ☒ NA
- Does this specialized training include sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☐ Yes ☐ No ☐ NA
- Does this specialized training include the criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).)
☐ Yes ☐ No ☒ NA

115.334 (c)

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

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.009a Investigation *(a)-1, p. 4, standards, s. 4
2. Written Policy and Procedures 13.8.1 *(a)-1, p.5, s. I, subs. B, subss.1-3
3. DYS Form 115.334 DYS Investigator Receipt of PREA
4. Certification of Criminal Investigators
5. Department of Mental Health Investigative Training Certificates
6. MOU with Local Law enforcement including training and certifications (Shelby County Sheriff's Department)
7. Agreement with CHIPS Center (Children's Hospital Intervention and Prevention Services)

Interviews:

1. Interview with Shelby County Sheriff's Department
2. Interview with the PREA Compliance Manager

King's Home does not conduct any form of administrative or criminal sexual abuse investigations. Investigators are employed with Shelby County Sheriff's Department and receive specialized training from the Alabama Bureau of Investigations (ABI) in sexual abuse investigations involving juveniles.

The Special Investigators Unit Training Curriculum includes:

(1) What is PREA; (2) Confined Settings and Sexual Abuse Investigations; (3) Receiving a Referral for a Sexual Abuse Investigation in a Confined Setting; (4) Gathering Information during a Sexual Abuse Investigation in a Confined Setting; (5) Conducting a Sexual Abuse Investigation within a Confined

Setting; (6) Interviewing Juvenile Sexual Abuse Victims; (7) Sexual Abuse Evidence Collection in Confinement Settings; (8) False Allegations; (9) Recanting Information; (10) Witnessing Sexual Abuse; (11) Substantiating a Case for Prosecution Referral; (12) Miranda Warning; and (13) Garrity Warning

General training provided to all employees pursuant to 115.331, investigators receive training in conducting investigations in confinement settings to include: Techniques for interviewing juvenile sexual abuse victims, Sexual abuse evidence collection in confinement settings, Criteria and evidence required to substantiate a case for administrative action or prosecution referral.

Corrective Action

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding specialized training: investigations. No corrective action is required.

Standard 115.335: Specialized training: Medical and mental health care

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

115.335 (a)

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

115.335 (b)

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

115.335 (c)

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

115.335 (d)

- Do medical and mental health care practitioners employed by the agency also receive training mandated for employees by §115.331? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
☒ Yes ☐ No ☐ NA
- Do medical and mental health care practitioners contracted by or volunteering for the agency also receive training mandated for contractors and volunteers by §115.332? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners contracted by or volunteering for the agency.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.002 Sexual Abuse Assault Harassment Training * (a)-1, pp. 2-3, s. A, subss. 1-4
2. Nurse Certification/Licenses
3. PREA Form 115.335 Medical and Mental Health Receipt of PREA
4. Training Records of Medical and Mental Health Practitioners
5. Rape Crisis Center/CHIPS Center (Children's Hospital Intervention and Prevention Services)

Interviews:

1. Interview with PREA Compliance Manager
2. Program Counselor

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.335 (a)

PAQ: The agency has a policy related to the training of medical and mental health practitioners who work regularly in its facilities.

1. The number of all medical and mental health care practitioners who work regularly at this facility who received the training: one (1)
2. The percent of all medical and mental health care practitioners who work regularly at this facility who received the training required by agency policy: 100%

The staff receives the eleven (11) PREA topics in standard 115.331 and the additional specialized topics required by the standard. All full and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: (1) How to detect and assess signs of sexual abuse and sexual harassment; (2) How to preserve physical evidence of sexual abuse; (3) How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and (4) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment.

115.335 (b)

PAQ: The agency does not employ medical staff that conduct forensic exams. Forensic medical examinations are performed offsite.

Policy requires specialized PREA training for medical and mental health staff. Documentation of specialized training was reviewed and confirmed by auditor. Forensic examinations are not conducted onsite. King's Home has an MOU with CHIPS Center (Children's Hospital Intervention and Prevention Services) and the Children's Hospital of Alabama in Birmingham, AL. staff will conduct forensic sexual assault medical exams.

115.335 (c)

PAQ: The agency maintains documentation showing that medical and mental health practitioners have completed the required training.

The auditor reviewed NIC Certificates, PREA Acknowledgement Statements, and the Staff Training Hours Report for verification prior to completion of final report.

115.335 (d)

Mental health staff receives the eleven (11) PREA topics in standard 115.331 and the additional specialized topics required by the standard.

The auditor reviewed training records. The Program Counselor received the specialized training and the training required by standard 113.331.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding specialized training for medical and mental health care. No corrective action is required.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

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

115.341 (a)

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

115.341 (b)

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

115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (1) Prior sexual victimization or abusiveness? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (3) Current charges and offense history? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (4) Age? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (5) Level of emotional and cognitive development? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (6) Physical size and stature? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (7) Mental illness or mental disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (8) Intellectual or developmental disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (9) Physical disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (10) The residents' own perception of vulnerability? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents? ☒ Yes ☐ No

115.341 (d)

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

115.341 (e)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.005 Reception and Orientation *(a) 1-2, pp. 2-3, s. 15, subss. a-k
*(a)-4 p. 3, paragraphs 2-3

2. DYS Policy 13.8.1 Protection from Sexual Abuse and Assault *(a)-1, pp. 11-12, s. IV, subs. A, 1-12 *(a)-2, p. 11, s. IV, subs. A *(a)-4, pp. 12-13, s. IV, subs. H
3. King's Home PREA Policy
4. DYS Form 115.341 Intake Screening for Assaultive Sexual Aggressive Behavior and Risk for Sexual Victimization (a)-1, (b)-1
5. DYS Form 115.341.1 PREA Risk Reassessment (a)-4
6. DYS Form 115.341.2 Guidelines for PREA Shared Information
7. Inappropriate Sexualized Behaviors Risk Assessment
8. King's Home Pre-Audit Questionnaire responses
9. High Risk Notification Alert Sheet

Interviews:

1. Interview with the PREA Compliance Manager
2. Interview with the Staff Responsible for Risk Screening
3. Interviews with Residents

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.341 (a)

PAQ: The agency has a policy that requires screening (upon admission to a facility or transfer to another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents. The policy requires that residents be screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their intake.

In the past 12 months:

1. The number of residents entering the facility (either through intake or transfer) whose length of stay in the facility was for 72 hours or more who were screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their entry into the facility: 21
2. The percent of residents entering the facility (either through intake or transfer) whose length of stay in the facility was for 72 hours or more who were screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their entry into the facility: 100%

The policy requires that a resident's risk level be reassessed periodically throughout their confinement.

During the intake process, DYS Assessment, Checklist, and Protocol for Behavior and Risk for Victimization is administered to residents within seventy-two (72) hours of admission. This information is ascertained through conversations with residents during the intake process and by reviewing relevant documentation. Each resident will be reassessed every six months or at any point of significant change in his or her situation.

The auditor reviewed completed DYS form Assessment, Checklist, and Protocol for Behavior and Risk for Victimization examples for verification.

The Staff Responsible for Risk Screening confirmed he screens residents upon admission to the facility or transfer from another facility for risk of sexual abuse victimization or sexual abusiveness toward other residents. He stated he screens residents for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their intake. The information is ascertained through conversations with residents during intake, medical and mental health screenings, and reviewing any relevant court records. Resident's risk levels are reassessed every six months.

Residents interviewed confirmed when they first came to the facility; they were asked questions like whether they have ever been sexually abused, whether they identify with being gay, bisexual or transgender, whether they have any disabilities, and whether they think they might be in danger of sexual abuse at the facility. They stated they were asked these questions the first or second day at the facility.

115.341 (b)

PAQ: Risk assessment is conducted using an objective screening instrument.

The auditor reviewed the Assessment, Checklist, and Protocol for Behavior and Risk for Victimization examples for verification. The screening instrument is designed to be objective.

115.341 (c)

The PREA Screening Report ascertains: prior victimization; and gender nonconforming appearance or manner or identification as LGBTI, and whether the resident may therefore be vulnerable to sexual abuse; current changes and offense history; age; level of emotional and cognitive development; physical size and stature; mental illness and disabilities; intellectual or developmental disabilities; physical disabilities; the resident's own perception of vulnerability; and any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents.

The Staff Responsible for Risk Screening confirmed the initial risk screening considers all aspects required by the standard.

115.341 (d)

This information shall be ascertained through conversations with the resident during the intake process and medical and mental health screenings; during classification assessments; and by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files.

The Staff Responsible for Risk Screening confirmed the information is ascertained through conversations with residents during intake, medical and mental health screenings, and reviewing any relevant court records.

115.341 (e)

Staff members working directly with the residents are advised of the status of a resident at risk of victimization or a resident that is at risk of harming others on a need to know basis.

The Program Director and, PREA Compliance Manager confirmed the agency has outlined who can have access to a resident's risk assessment within the facility, in order to protect sensitive information from exploitation. The information is available on a need-to-know basis.

During the last 12 months 21 youth have been screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their entry into the facility. The policy limits staff access to this information on a "need to know basis". The PREA Screening Report ascertains: prior victimization; and gender nonconforming appearance or manner or identification as LGBTI, and whether the resident may therefore be vulnerable to sexual abuse; current changes and offense history; age; level of emotional and cognitive development; physical size and stature; mental illness and disabilities; intellectual or developmental disabilities; physical disabilities; the resident's own perception of vulnerability; and any other specific information about individual residents that may indicate

heightened needs for supervision, additional safety precautions, or separation from certain other residents. Resident and staff interviews and review of document confirms the use of this instrument.

Corrective Action

Based upon review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding obtaining information from residents. No corrective action is required.

Standard 115.342: Use of screening information

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

115.342 (a)

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

115.342 (b)

- Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all residents safe can be arranged? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA
- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA
- During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

- Do residents in isolation receive daily visits from a medical or mental health care clinician? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA
- Do residents in isolation also have access to other programs and work opportunities to the extent possible? (N/A if the facility *never* places residents in isolation for any reason.) ☐ Yes ☐ No ☒ NA

115.342 (c)

- Does the agency always refrain from placing lesbian, gay, and bisexual (LGB) residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No
- Does the agency always refrain from placing transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No
- Does the agency always refrain from placing intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No
- Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex (LGBTI) identification or status as an indicator or likelihood of being sexually abusive? ☒ Yes ☐ No

115.342 (d)

- When deciding whether to assign a transgender or intersex resident to a facility for male or female residents, does the agency consider, on a case-by-case basis, whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems (NOTE: if an agency by policy or practice assigns residents to a male or female facility on the basis of anatomy alone, that agency is not in compliance with this standard)? ☒ Yes ☐ No
- When making housing or other program assignments for transgender or intersex residents, does the agency consider, on a case-by-case basis, whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems? ☒ Yes ☐ No

115.342 (e)

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

115.342 (f)

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

115.342 (g)

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

115.342 (h)

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

115.342 (i)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

- DYS-P.001 Protection from Sexual Abuse and Assault *(b)-1 and (b)-2, p. 8, s. C, subs. 2 *(c)-1 and (c)-2. p. 9, s. C, subss. 3-4
- DYS Policy 13.1 Nondiscrimination for Students
- DYS Policy 13.8.1 Protection from Sexual Abuse and Assault *(a)-1, pp. 13-14, s. VI, subs. A *(b)-1, p. 14, s. VI, subs. B *(b)-2, p. 14, s. VI, subs. B *(c)-1, p. 14, s. VI, subs. C *(c)-2, p. 14, s. VI, subs. C *(i)-1, p. 14, s. VI, subs. B

4. DYS Form 115.342 Housing Unit Placement Form
5. Health Screening

Interviews:

1. Interview with the Program Director
2. Interview with Staff Responsible for Risk Screening
3. Interview with Staff who Supervise Residents in Isolation – N/A
4. Interviews with Transgendered/Intersex/Gay/Lesbian/Bisexual Residents – N/A
5. Residents in Isolation (for risk of sexual victimization/who allege to have suffered sexual abuse) – N/A
6. Interviews with Residents

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.342 (a)

PAQ: The agency/facility uses information from the risk screening required by §115.341 to inform housing, bed, work, education, and program assignments with the goal of keeping all residents safe and free from sexual abuse.

The “At-Risk Protocol” will be initiated and completed by each facilities respective PREA Compliance Manager or their designee on residents identified as vulnerable for at risk sexual victimization or identified as having the potential to victimize/ perpetrate, especially in regards to sexually aggressive behavior. Bed and room assignments will be made accordingly on a case by case basis.

The PREA Compliance Manager and Staff Responsible for Risk Screening confirmed the facility uses information from the risk screening during intake to keep residents safe and free from sexual abuse and sexual harassment by determining housing and programming assignments.

The auditor reviewed At-Risk Protocol examples demonstrating risk assessment factors are considered in keeping residents safe and free from sexual abuse.

115.342 (b)

PAQ: The facility has a policy that residents at risk of sexual victimization may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged. The facility policy requires that residents at risk of sexual victimization who are placed in isolation have access to legally required educational programming, special education services, and daily large-muscle exercise. In the past 12 months:

1. The number of residents at risk of sexual victimization who were placed in isolation: 0
2. The number of residents at risk of sexual victimization who were placed in isolation who have been denied daily access to large muscle exercise, and/or legally required education, or special education services: 0
3. The average period of time residents at risk of sexual victimization who were held in isolation to protect them from sexual victimization: N/A

The Program Director confirmed King’s Home does not use isolation.

115.342 (c)

PAQ: The facility prohibits placing lesbian, gay, bisexual, transgender, or intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status. The facility prohibits considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

Placing lesbian, gay, bisexual, transgender, or intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status is prohibited. Considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of the likelihood of being sexually active is prohibited.

The PREA Coordinator and PREA Compliance Manager confirmed gay, bisexual, transgender, or intersex residents are not placed in particular housing, bed, or other assignments solely on the basis of such identification or status, nor does the facility consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

The auditor observed no designated LGBTI housing at King's Home.

115.342 (d)

PAQ: The agency or facility makes housing and program assignments for transgender or intersex residents in the facility on a case-by-case basis.

The PREA Compliance Manager confirmed housing and programming assignments for transgender and intersex residents are considered on a case-by-case basis whether the placement would ensure the resident's health and safety, and whether the placement would present management or security problems. However, the facility did not house any transgender and intersex residents during the audit process.

115.342 (e)

PAQ: Placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident.

Each resident will be reassessed every six months or at any point of significant change in his or her situation. The PREA Compliance Manager and Staff Responsible for Risk Screening confirmed placement and programming assignments are reassessed at least twice each year to review any threats to safety experienced by the resident.

115.342 (f)

PAQ: A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration.

The PREA Compliance Manager and Staff Responsible for Risk Screening confirmed a transgender or intersex resident's own views with respect to his or her own safety is given serious consideration.

115.342 (g)

PAQ: Transgender and intersex residents shall be given the opportunity to shower separately from other residents.

All King's Home residents shower separately.

The PREA Coordinator and Staff Responsible for Risk Screening confirmed transgender and intersex residents are given the opportunity to shower separately from other residents.

115.342 (h)

PAQ: From a review of case files of residents at risk of sexual victimization who were held in isolation in the past 12 months, the number of case files that include BOTH:

1. A statement of the basis for facility's concern for the resident's safety, and
2. The reason or reasons why alternative means of separation cannot be arranged: N/A

If a resident is isolated pursuant to paragraph (b) of this section, the facility shall clearly document:

- (1) The basis for the facility's concern for the resident's safety; and
- (2) The reason why no alternative means of separation can be arranged.

115.342 (i)

PAQ: If a resident at risk of sexual victimization is held in isolation, the facility affords each such resident a review every 30 days to determine whether there is a continuing need for separation from the general population.

King's Home prohibits the use of isolation. The auditor observed a time out room which would only be utilized long enough to make a different room assignment.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding use of screening information. No corrective action is required.

REPORTING

Standard 115.351: Resident reporting

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

115.351 (a)

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

115.351 (b)

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

115.351 (c)

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

115.351 (d)

- Does the facility provide residents with access to tools necessary to make a written report? ☒ Yes ☐ No
- Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.001 Protection from Sexual Abuse and Assault *(a)-1, p. 9, s. D, subss. 1-4
2. PREA Audit Report 18
3. DYS Policy 13.8.1 Protection from Sexual Abuse and Assault *(a)-1, p. 16, s. VIII, subs. C *(b)-2, p. 16, s. VIII, subs. I *(c)-1, p. 16, s. VIII, subs. F *(c)-2, p. 16, s. VIII, subs. G *(e)-1, p. 16, s. VIII, subs. G
4. Written Policy and Procedures 1.28 *(a)-1, pp. 7-9, s. III, subss. E, 1-14 *(d)-1, pp. 4-5, s. III, subss. C, 1-6
5. Resident Handbook
6. DYS Form 115.351 Alabama Hotline Message
7. DYS Form 115.333.1 Resident Receipt of PREA
8. DYS Form 115.354 Third Party Reporting
9. DYS Form 1.28 DYS Youth Grievance Form
10. Poster: 5 Ways of Reporting
11. Juvenile Report Abuse or Harassment to a Public or Private Entity or Office

Interviews:

1. Interview with the PREA Compliance Manager
2. Interviews with a Random Sample of Staff
3. Interviews with Residents
4. Interviews with Residents who Reported a Sexual Abuse – N/A

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.351 (a)

PAQ: 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.

The facilities provide internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. Internal ways of reporting include reporting to facility/agency personnel or filing a grievance. Grievance forms and locked grievance boxes are assessable to the residents. A grievance form is included in each resident handbook. Residents have access to pencils for writing grievances and the grievance box is checked daily.

Staff interviews confirmed residents can privately report sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, or staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment by calling the hotline number. Residents stated they would report sexual abuse or sexual harassment that happened to them or someone else by telling staff, calling the hotline, or writing a grievance.

115.351 (b)

PAQ: The agency provides at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency. The agency has a policy requiring residents detained solely for civil immigration purposes be provided information on how to contact relevant consular officials and relevant officials of the Department of Homeland Security.

Residents may also report externally to a public or private entity or office that is not part of the agency. This includes but is not limited to: (1) DYS Child Abuse Hotline at 1-855-332-1594 (2) Attorney or Guardian; (3) The CHIPS Center (Children's Hospital Intervention and Prevention Services) (4) DYS PREA Coordinator at 1-334-604-4233 (5) The Shelby County Sheriff's Department at 1-205-669-4557 and (6) Children's Hospital Emergency Room at 1-205-638-9100, residents may remain anonymous upon request.

Residents detained solely for civil immigration purposes are provided information on how to contact relevant consular officials and relevant officials at the Alabama Department of Homeland Security at 1-334-353-3050. The facility has not had any residents detained solely for civil immigration purposes.

The PREA Compliance Manager identified the DYS Child Abuse Hotline as one way residents can report sexual abuse or sexual harassment to a public or private entity that is not part of the agency. Calling the hotline enables receipt and immediate transmission of resident reports of sexual abuse or sexual harassment to agency officials and allows the resident to remain anonymous upon request. Residents stated they would report sexual abuse or sexual harassment that happened to them or someone else by telling staff, calling the hotline, or writing a grievance. Residents also could identify someone that does not work at the facility they could report to.

The auditor observed English and Spanish language posters with phone numbers and/or mailing addresses for resident access to outside support services.

115.351 (c)

PAQ: The agency has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties. Staff is required to document verbal reports. The time frame that staff is required to document verbal reports:

Interviews with staff confirmed when a resident alleges sexual abuse or sexual harassment; they can do so verbally, in writing, anonymously and through third parties. Staff stated they document verbal reports. Most said immediately, but all stated they would document within 24 hours. Residents confirmed they can make reports of sexual abuse or sexual harassment either in person or in writing and someone else could make the report for them, so they do not have to give their name.

115.351 (d)

PAQ: The facility provides residents with access to tools to make written reports of 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.

The PREA Compliance Manager confirmed residents are allowed to have a pencil to make written reports of 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. The auditor observed grievance forms are available next to locked grievance boxes. The facility grievance box is checked daily and the DYS Box is checked monthly.

115.351 (e)

PAQ: The agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents.

The facility allows for staff to privately report sexual abuse and sexual harassment of residents by calling the DYS Child Abuse Hotline at 1-855-332-1594. Staff interviewed identified the DYS Child Abuse Hotline as a way for them to privately report sexual abuse and sexual harassment of residents.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding resident reporting. No corrective action is required.

Standard 115.352: Exhaustion of administrative remedies

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

115.352 (a)

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

115.352 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☐ NA
- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (e)

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

- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)
☐ Yes ☐ No ☒ NA
- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegation of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.)
☐ Yes ☐ No ☒ NA
- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)
☐ Yes ☐ No ☒ NA
- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA
- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☐ Yes ☐ No ☒ NA

115.352 (g)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P 004 Youth Grievance Process *(a)-1, pp. 6-7, s. E, subss. 1-14
2. DYS Policy 13.1 Youth Grievance Process
3. DYS Policy 13.8.1 Protection from Sexual Abuse and Assault *(a)-1 pp. 7-10, s. E. subs. 1-14*(c)-1&2, p. 7, s. E, subs. 4*(d)-1, p. 8, s. E, subs. 5-6*(e)-1, p. 8, s. E, subs. 9-10 *(e)-2, p. 9, s. E, subs.11 *(e)-3, p. 9, s. E, subs., 12 *(f)-1, p. 9, s. E, subss. 13-14 *(f)-2, p. 9, s. E, subs. 14 *(f)-5, p. 9, s. E, subss. 14 *(g)-1, p. 10, s. F
4. Juvenile Grievance and Response
5. DYS Form 115.333.1 Juvenile Receipt of PREA
6. DYS Form 115.354 Third Party Reporting

Interviews:

1. Interviews with Residents who reported a Sexual Abuse - N/A

Site Review Observations:

Observations during on-site review of physical plant

Findings:

PAQ: In the past 12 months:

The number of grievances that were filed that alleged sexual abuse: Zero (0)

King's Home is exempt from this standard. King's Home does not have administrative procedures to address resident grievances regarding sexual abuse. DYS is responsible for all administrative procedures to address resident grievances regarding sexual abuse.

Residents may report allegations of sexual abuse at any time regardless of when the incident is alleged to have occurred. Residents are not required to nor should they attempt to resolve with staff an alleged incident of sexual abuse. Incidents are not required to be and should not be referred to the staff member who is the subject of the complaint.

Residents may get assistance in filing requests for administrative remedies relating to allegations of sexual abuse from third parties. Third parties may also file such requests on behalf of residents. If the

resident declines to have third-party assistance in filing a grievance alleging sexual abuse, staff members of King's Home must document the resident's decision to decline.

The auditor reviewed the resident handbook to determine that relevant information is provided. The auditor observed a locked grievance box that is checked daily.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding exhaustion of administrative remedies. No corrective action is required.

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

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

115.353 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No
- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? (N/A if the facility *never* has persons detained solely for civil immigration purposes.) ☒ Yes ☐ No ☐ NA
- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.353 (b)

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

115.353 (c)

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

115.353 (d)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.001 Protection from Sexual Abuse and Assault*(a)-1, (d)-1 and (d)-2, pp. 13-14, s. I, 1-4
2. DYS Policy 13.8.1 Protection from Sexual Abuse and Assault *(a)-1, p. 25, s. XVII, subs. A *(d)-1, p. 25, s. XVII, subs. D *(d)-2, p. 25, s. XVII, subs. D
3. Memorandum of Agreement with CHIPS Center (Children's Hospital Intervention and Prevention Services)
4. Examples of Posters
5. DYS Form 115.351 Alabama PREA Hotline Message
6. Resident Handbook
7. PREA Form 115.333 Juvenile Receipt of PREA
8. Important Numbers for Juveniles to Report Sexual Abuse
9. Access to Outside Support Services

Interviews:

1. Interview with the PREA Compliance Manager
2. Interview with the Program Director
3. Interviews with Residents
4. Interviews with Residents who Reported a Sexual Abuse - N/A

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):**115.353 (a)**

PAQ: The facility provides resident's access to outside victim advocates for emotional support services related to sexual abuse by:

1. Giving residents (by providing, posting, or otherwise making accessible) mailing addresses and telephone numbers (including toll-free hotline numbers where available) of local, State, or national victim advocacy or rape crisis organizations.
2. Enabling reasonable communication between residents and these organizations, in as confidential a manner as possible.

King's Home provides residents with access to outside victim advocates for emotional support services related to sexual abuse. The facility has a MOU with CHIPS Center (Children's Hospital Intervention and Prevention Services). CAC has a Child Abuse Hotline Number. King's Home also provides the residents with a mailing address, email address, telephone number, and hotline number for the Alabama Department of Youth Services. This information is provided as part of the resident PREA education. For persons detained solely for civil immigration purposes, immigrant services agency information is available to contact the Alabama Department of Homeland Security.

Residents acknowledged there are services available outside of this facility for dealing with sexual abuse if they ever need it. They confirmed they knew about the availability of a victim advocate and knew the information was included in their handbooks and posted on the walls. They confirmed they would be able to talk with people from outside services when needed and the call would be private.

115.353 (b)

PAQ: The facility informs residents, prior to giving them access to outside support services, the extent to which such communications will be monitored. The facility informs residents, prior to giving them access to outside support services, of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant Federal, State, or local law.

The facilities inform residents, prior to giving them access, of the extent to which such communications will be monitored. The facilities enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible. Telephone calls are monitored with sight, but not sound supervision.

Interviews with residents confirmed they were knowledgeable of mandatory reporting rules when having conversations with people from outside services.

115.353 (c)

PAQ: The agency or facility maintains memoranda of understanding (MOUs) or other agreements with community service providers that are able to provide residents with emotional support services related to sexual abuse. The agency or facility maintains copies of those agreements.

The facility has a MOU with CHIPS Center (Children's Hospital Intervention and Prevention Services) who has a Child Abuse Hotline Number. King's Home also provides the residents with a mailing address, email address, telephone number, and hotline number for the CHIPS Center (Children's Hospital Intervention and Prevention Services). This information is provided as part of the resident PREA education.

115.353 (d)

PAQ: The facility provides residents with reasonable and confidential access to their attorneys or other legal representation. The facility provides residents with reasonable access to parents or legal guardians.

If a resident request to consult with their attorney, the resident's Program Counselor will contact youth's attorney and request the consultation. Residents may make phone calls to immediate family only or others approved by the court or your DYS Family Service Worker.

The Program Director and PREA Compliance Manager confirmed the facility would provide residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians. Residents confirmed the facility allows them to see or talk with their lawyer or another lawyer and they are allowed to talk with that person privately. Residents also confirmed the facility allows them to see or talk with their parents or someone else such as a legal guardian.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility meets this standard regarding resident access to outside confidential support services and legal representation by providing a range of outside support services. No corrective action is required.

Standard 115.354: Third-party reporting

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

115.354 (a)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.001 Protection from Sexual Abuse and Assault *(a)-1, p. 10, s. D, subs. 5

2. DYS Policy 13.8.1 Protection from Sexual Abuse and Assault (a)-1, p. 16, s. VIII, subss. E-F
3. DYS Form 115.354 Alabama PREA Third Party Reporting Form

Interviews:

1. Interview with the Program Director
2. Interview with PREA Compliance Manager
3. Interviews with Residents

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):**115.354 (a)**

PAQ: The agency or facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment.

Third parties, including parents, other residents, or any other person may report allegations of resident sexual abuse or sexual harassment. Parents/Legal Guardians are provided a handbook containing a grievance form and procedures for reporting.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding third-party reporting. No corrective action is required.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

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

115.361 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No
- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

115.361 (b)

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

115.361 (c)

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

115.361 (d)

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

115.361 (e)

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

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified?
☒ Yes ☐ No
- If an alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? ☒ Yes ☐ No
- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation? ☒ Yes ☐ No

115.361 (f)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.001 Protection from Sexual Abuse and Assault *(a)-1 and (b)-1, pp. 10-11, s. E, subbs. 1-10
2. Written Policy and Procedures 1.29 *(a)-1, p. 4, s. A, subss. 1-2
3. Written Policy and Procedures 13.8.1 *(a)-1, p. 16, s. VIII, subs. H *(b)-1, p. 17, s. X, subs. D
4. Written Policy and Procedures 13.16 *(b)-1, p. 2, s. E
5. Code of Alabama: 26-14-3. Mandatory reporting
6. DYS Form 8.12 Critical Incident Report
7. PREA Form 115.331 Staff Receipt of PREA
8. PREA Form 115.354 Third Party Reporting
9. Confirmation of Parent/Attorney/ Guardian Notification

10. PREA Form 115.381 Consent to Treatment
11. PREA Form 115.341.2 Guidelines for PREA Shared Information
12. DHR-FCS-1593 Child Abuse Reporting Form

Interviews:

1. Interview with the PREA Compliance Manager
2. Interview with the Program Director
3. Interviews with a Random Sample of Staff
4. Interviews with Program Counselor

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):**115.361 (a)**

PAQ: The agency requires all staff to report immediately and according to agency policy:

1. Any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency.
2. Any retaliation against residents or staff who reported such an incident.
3. Any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

Duty to Report - Code of Alabama: 26-14-3. Mandatory reporting Laws requires all staff to report immediately and according to policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

Staff confirmed the agency requires all staff to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Staff stated they would report to their immediate supervisor.

115.361 (b)

PAQ: The agency requires all staff to comply with any applicable mandatory child abuse reporting laws.

All staff is required to follow the Alabama Mandated Reporter Law - Alabama Code Annotated 26-14-3.

Staff confirmed PREA training includes how to comply with relevant laws related to mandatory reporting of sexual abuse.

115.361 (c)

PAQ: Apart from reporting to designated supervisors or officials and designated State or local service agencies, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions.

Apart from reporting to designated supervisors/superintendents, DYS and local law enforcement agencies, staff are prohibited from revealing any information related to a sexual abuse report to

anyone, other than to the extent necessary, to make treatment, investigation and other security and management decisions.

Staff confirmed the agency requires all staff to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Staff stated they would report to their immediate supervisor.

115.361 (d)

Therapists are required to report sexual abuse and sexual harassment to the DYS Child Abuse Hotline. They are mandated to follow Duty to Report laws. Therapists are required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality.

115.361 (e)

Upon receiving any allegation of sexual abuse, the Residential Managers shall promptly report the allegation to the alleged victim's parents or legal guardians, unless King's Home has official documentation showing the parents or legal guardians should not be notified. If the alleged victim is under the guardianship of DYS, the report shall be made to the alleged victim's Family Services Worker instead of the parents or legal guardians.

The Program Director/PREA Compliance Manager confirmed when the facility receives an allegation of sexual abuse the allegation is reported the Program Director and the Program Director notifies the victim's legal guardians as appropriate. If the victim is under the guardianship of the child welfare system; the allegation would be reported to the DYS Family Services Worker. If a juvenile court retains jurisdiction over the alleged victim, the juvenile's attorney would be notified. These notifications would occur the same day of the allegation.

115.361 (f)

All allegations of sexual abuse must be reported immediately to the DYS Child Abuse Hotline at 1-855-332-1954.

King's Home requires all staff to report immediately any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in the Facility; retaliation against a resident or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation.

Medical and mental health staff is required to inform the residents at the initiation of services of their duty to report and the limitations of confidentiality. Staff is prohibited from revealing any information related to a sexual abuse report to anyone other than to make treatment, investigation, and other security and management decisions. The facility reports all allegations of sexual abuse and sexual harassment, including third-party and anonymous reports, to the Shelby County Sheriff's Department.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding staff and agency reporting duties. No corrective action is required.

Standard 115.362: Agency protection duties

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

115.362 (a)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS Written Policy and Procedures 13.8.1 *(a)-1, p. 13, s. V
2. DYS Form 8.12 Critical Incident Form
3. PREA Form 115.342 Housing Unit Placement Form
4. PREA Form 115.342.1 Isolation Activity Log

Interviews:

1. Interview with the Agency Head Designee
2. Interview with the Program Director
3. Interviews with Staff

Site Review Observations:

Observations during on-site review of physical plant

Findings:

PAQ: When the agency or facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident (i.e., it takes some action to assess and implement appropriate protective measures without unreasonable delay).

In the past 12 months:

1. The number of times the agency or facility determined that a resident was subject to substantial risk of imminent sexual abuse: Zero (0)

King's Home requires that upon learning a resident is subject to a substantial risk of imminent sexual abuse immediate action shall be taken to protect the resident. Staff will immediately report to the DYS Child Abuse Hotline.

The Agency PREA Coordinator confirmed that immediate actions will be taken to protect a resident who is subject to a substantial risk of imminent sexual abuse. Protective measures would include separating the potential victim from the potential aggressor, safety plans, and one-on-one supervision.

The Program Director confirmed when he learns that a resident is subject to a substantial risk of imminent sexual abuse, the facility would take immediate protective actions such as separating youth. He confirmed staff should respond immediately to protect residents at substantial risk of imminent sexual abuse.

Staff confirmed they would immediately separate a potential victim from harm and provide close observation.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding agency protection duties. No corrective action is required.

Standard 115.363: Reporting to other confinement facilities

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

115.363 (a)

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

115.363 (b)

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

115.363 (c)

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

115.363 (d)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.001 Protection from Sexual Abuse and Assault*(a)-1 and (d)-1, p. 11, s. F, subbs. 1-4
2. Written Policy and Procedures 13.8.1 *(a)-1, 2, pp. 18-19, S. XI, subss. A-D *(d)-1, p. 19, S. XI, subss. C
3. PREA Form 115.363 Reporting to Other Confinement Facilities
4. King's Home Pre-Audit Questionnaire responses
5. DYS Protocol: First Responder Guidelines for Sexual Assault

Interviews:

1. Interview with the Agency Head Designee
2. Interview with the Program Director

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.363 (a)

PAQ: The agency has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. The agency's policy also requires that the head of the facility notify the appropriate investigative agency. In the past 12 months, the number of allegations the facility received that a resident was abused while confined at another facility: Zero (0)

Upon receiving an allegation of sexual abuse or sexual harassment when a resident was confined at another facility/agency, King's Home's PREA Compliance Manager will notify the head of the facility/agency where the alleged abuse occurred no later than 72 hours of receiving the allegation and will report the abuse incident directly to the DYS Child Abuse Hotline at 1-855-332-1594. Such contacts will be documented.

115.363 (b)

PAQ: Agency policy requires that the facility head provides such notification as soon as possible, but no later than 72 hours after receiving the allegation.

King's Home's PREA Coordinator will notify the head of the facility /agency where the alleged abuse occurred no later than 72 hours of receiving the allegation.

115.363 (c)

PAQ: The agency or facility documents that it has provided such notification within 72 hours of receiving the allegation.

Such contacts will be documented within 72 hours of receiving the allegation.

115.363 (d)

PAQ: Agency/facility policy requires that allegations received from other facilities/agencies are investigated in accordance with the PREA standards. The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards. In the past 12 months, the number of allegations of sexual abuse the facility received from other facilities: Zero (0)

King's Home's PREA Coordinator reports the abuse incident directly to the DYS Child Abuse Hotline at 1-855-332-1594 for investigation.

The Agency PREA Coordinator stated DYS is the designated point of contact if another facility refers allegations of sexual abuse or sexual harassment. The Program Director confirmed that all allegations reported to have occurred at another facility will be referred to DYS investigations. The director of the facility where the abuse is alleged to have occurred will be notified within 72 hours. He stated there are no examples of this occurring.

There have been no reports from other facilities related to sexual abuse or harassment of a resident placed at King's Home. Agency policy serves as the guide should the event ever occur. Upon receiving an allegation that a juvenile was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the facility where the alleged abuse occurred and shall also notify the appropriate investigative agency using PREA form 115.363 Reporting to Other Confinement Facilities.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding reporting to other confinement facilities. No corrective action is required.

Standard 115.364: Staff first responder duties

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

115.364 (a)

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

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

115.364 (b)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.001 Protection from Sexual Abuse and Assault *(a)-1, pp. 11-12, s. G, subbs. 1a-e
2. Written Policy and Procedures 13.8.1 *(a)-1, p. 19, s. XII, subbs. 1-5
3. PREA Form 115.331 Staff Receipt of PREA
4. PREA Form 115.364 First Responder Checklist
5. PREA Form 115.364.1 First Responder Guidelines for Sexual Assault

Interviews:

1. Interview with Program Director

2. Interview with PREA Compliance Manager

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.364 (a)

PAQ: The agency has a first responder policy for allegations of sexual abuse. The agency policy requires that, upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to:

1. Separate the alleged victim and abuser;
2. Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence;
3. If the abuse occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and
4. If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.

In the past 12 months, the number of allegations that a resident was sexually abused: One (1)

Of these allegations, the number of times the first non-security staff member to respond to the report separated the alleged victim and abuser: zero (0)

In the past 12 months, the number of allegations where staff were notified within a time period that still allowed for the collection of physical evidence: zero (0)

Upon receiving notice of an incident of sexual abuse by a resident, or if an employee witnesses or unexpectedly encounters an assault taking place, the employee will ensure the resident is kept safe and kept separated from the perpetrator, immediately notifying the Residential Manager or Manager on call, and:

1. Ensure resident does not change clothes, shower, wash, brush teeth, rinse mouth, eat, drink, or use the toilet until all physical evidence is obtained in connection with the violation: and
2. Secure the incident area and treat it as a crime scene.

Staff should refer to the DYS Protocol: First Responder Guidelines for Sexual Assault for guidelines on responding to sexual assaults. The protocol is reviewed with each staff upon hire, during orientation, and maintained in the tech staff office of each residential facility.

The DYS Protocol: First Responder Guidelines for Sexual Assaults provides in-depth guidelines regarding emergency medical attention, evidence collection, and treating both the victim's and perpetrator's bodies as crime scenes to safeguard evidence.

Interviews with Staff First Responders confirmed they were knowledgeable of their first responder duties.

115.364 (b)

PAQ: The agencies policy requires that if the first staff responder is not a security staff member, that responder shall be required to:

1. Request that the alleged victim not take any actions that could destroy physical evidence.

2. Notify security staff.

King's Home does not employ security staff. All staff are trained on the First Responder Guidelines for Sexual Assault for guidelines on responding to sexual assaults.

Interviews with staff confirmed they are knowledgeable of their first responder duties.

The auditor reviewed the agency protocol for "staff first responder duties". All areas were covered to include duties for security and non-security staff members. There has been one (1) allegation that a resident was sexually abused within the last 12 months. Random staff interviews revealed considerable knowledge of actions to be taken upon learning that a resident was sexually abused.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding staff first responder duties. No corrective action is required.

Standard 115.365: Coordinated response

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

115.365 (a)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. Written Institutional Plan

Interview:

Interview with the Program Director

Interview with the PREA Compliance Manager

Site Review Observation:

Observations during on-site review of physical plant

Findings:

PAQ: The facility has developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership.

The DYS Protocol: First Responder Guidelines for Sexual Assault coordinates actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership.

The Program Director confirmed the facility has a written institutional plan to coordinate actions taken in response to an incident of sexual abuse. The DYS Protocol: First Responder Guidelines for Sexual Assault coordinates actions among staff first responders and facility leadership.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding a coordinated response. No corrective action is required.

Standard 115.366: Preservation of ability to protect residents from contact with abusers**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report****115.366 (a)**

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

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. Written Policy and Procedures 13.8.1 *(a) 1 p.17, s. X. subs. B,5
2. Notification Letter
3. Administrative Leave Letter
4. King's Home Pre-Audit Questionnaire responses

Interview:

Interview with the Agency Head Designee (PREA Compliance Coordinator)

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.366 (a)

PAQ: The agency, facility, or any other governmental entity responsible for collective bargaining on the agency's behalf has not entered into or renewed any collective bargaining agreement or other agreement since the last PREA audit.

King's Home does not have a collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.

The PREA Coordinator confirmed King's Home has not entered into or renewed any collective bargaining agreements.

115.366 (b)

King's Home has not entered into or renewed any collective bargaining agreements.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding preservation of the ability to protect residents from contact with abusers. No corrective action is required.

Standard 115.367: Agency protection against retaliation

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

115.367 (a)

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

115.367 (b)

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

115.367 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: The conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: The conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Any resident disciplinary reports? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Resident housing changes? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Resident program changes? ☒ Yes ☐ No
- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Negative performance reviews of staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor:
Reassignments of staff? ☒ Yes ☐ No
- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

115.367 (d)

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

115.367 (e)

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

115.367 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.008 Protections Against Retaliation *(a)-1, p. 1, paragraph
2. Written Policy and Procedures 13.8.1 *(a)-1, p. 22-23, s. XV, subss. A-G
3. PREA Form 115.342 Housing Unit Placement Form
4. PREA Form 115.367 Protections Against Retaliation
5. Treatment Notes
6. PREA form 115.171 Investigative Outcome
7. King's Home Pre-Audit Questionnaire responses

Interviews:

1. Interview with the Agency Head Designee
2. Interview with the Program Director
3. Interview with the Designated Staff Member Charged with Monitoring Retaliation
4. Interview with Residents in Isolation (for risk of sexual victimization/who allege to have suffered sexual abuse) - N/A
5. Interview with Residents who Reported a Sexual Abuse – N/A

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):**115.367 (a)**

PAQ: The agency has a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff.

The Agency designates staff member(s) or charges department(s) with monitoring for possible retaliation.

The name(s) of the staff member(s): LaQuarey Files

The title(s) of the staff member(s): Program Counselor

Retaliation or negative consequences for reporting sexual abuse/ harassment or cooperating with sexual abuse/ harassment investigations will not be tolerated and may result in disciplinary action up to and including termination.

115.367 (b)

The PREA Coordinator stated protective measures would be made on a case-by-case basis to ensure that all staff and residents are being treated fairly. Staffing changes, housing changes, and safety plans would be made as needed. The Program Director stated the facility would make housing changes or transfers, remove alleged abusers, provide emotional support services, and increase staff supervision. The Designated Staff Member Charged with Monitoring Retaliation, he stated the different measures he would take to protect residents and staff from retaliation would be the same. He confirmed he would initiate contact with residents who have reported sexual abuse. Contact would occur at least weekly through the treatment team.

115.367 (c)

PAQ: The agency and/or facility monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff.

The length of time that the agency and/or facility monitor the conduct or treatment: 90 days

The agency/facility acts promptly to remedy any such retaliation. The agency/facility continues such monitoring beyond 90 days if the initial monitoring indicates a continuing need. The number of times an incident of retaliation occurred in the past 12 months: Zero (0)

For a period of ninety (90) days following a report, the PREA Coordinator, along with the respective PREA Compliance Manager, will monitor the treatment of residents or staff that made a report and the resident who were reported to be abused to identify attempts at retaliation or negative consequences and will act immediately to remedy any such actions. Monitoring will include, but not be limited to:

1. Resident disciplinary reports (Behavioral Reviews)
2. Negative staff reviews or requests for transfers

3. Periodic status checks of residents

The Program Counselor stated the measures he would take if he suspects retaliation; that includes talking with staff and youth, interviewing staff and residents and providing consequences of retaliation. As the Designated Staff Member Charged with Monitoring Retaliation, he stated things he looks for to detect possible retaliation includes staff giving too many consequences. He monitors disciplinary reports and periodic status checks. He stated he would monitor the conduct and treatment of residents and staff who report the sexual abuse of a resident or were reported to have suffered sexual abuse for 90 days. If there is concern that potential retaliation might occur, the maximum length of time that the facility would monitor conduct and treatment would be until a youth expresses no further retaliation or is released.

115.367 (d)

Policy states monitoring will include periodic status checks of residents.

The Designated Staff Member Charged with Monitoring Retaliation confirmed monitoring would include periodic status checks.

115.367 (e)

If any individual involved in a report expresses fear of retaliation, appropriate measures will be taken to protect that individual.

The Program Director stated if an individual who cooperates with an investigation expresses fear of retaliation, the agency takes measures to protect that individual against retaliation including developing a safety plan and providing emotional support from the therapist. The Program Director stated the different measures he would take to protect residents and staff from retaliation would include housing changes or transfers, remove alleged abusers, provide emotional support services, and increase staff supervision. He stated measures he would take when he suspects retaliation would be the same.

115.367 (f)

Policy states responsibility to monitor will terminate if the allegation is found to be unfounded.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the facility is fully compliant with this standard regarding agency protection against retaliation. No corrective action is required.

Standard 115.368: Post-allegation protective custody

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

115.368 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.001 Protection from Sexual Abuse and Assault *(a)-1, p. 8, s. C, subs. 2
2. Written Policy and Procedures 13.8.1 *(a)-1, p. 14, s. VI, subs. B
3. PREA Form 115.342 Housing Unit Placement Form
4. PREA Form 115.342.1 Isolation Activity Log
5. King's Home Pre-Audit Questionnaire responses

Interview:

1. Interview with the Program Director

Site Review Observations:

Observations during on-site review of physical plant

Findings:

PAQ:

The number of residents who allege to have suffered sexual abuse who were placed in isolation: Zero (0)

King's Home does not use of segregated housing or isolation to protect a resident who is alleged to have suffered sexual abuse. One-on-one supervision, safety plans, and other protective measures would be used.

The Program Director confirmed the facility does not use segregated housing or isolation to protect residents who are alleged to have suffered sexual abuse.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding post-allegation protective custody. No corrective action is required.

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

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

115.371 (a)

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

115.371 (b)

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

115.371 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No
- Do investigators interview alleged victims, suspected perpetrators, and witnesses? ☒ Yes ☐ No
- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.371 (d)

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

115.371 (e)

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

115.371 (f)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?
☒ Yes ☐ No
- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

115.371 (g)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No
- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

115.371 (h)

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

115.371 (i)

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

115.371 (j)

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

115.371 (k)

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

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.006 Referrals of Sexual Assault Abuse Harassment Allegations for Investigations (a)-1, p. 1, paragraph 1
2. Records Retention Schedule (refer to DYS-P.006 (page 2, section 9)
3. Written Policy and Procedures 13.8.1 *(a)-1, pp. 19-21, s. XIII, subss. 1-16
4. Records Retention Schedule *(j)-1, p. 20-21, s. XIII, subs. 11
5. PREA Form 115.371 Process for Investigating Sexual Assault Allegation
6. PREA form 115.371.1 Investigative Outcome
7. Credentials for Investigators
8. Agreement with Shelby County Sheriff's Department
9. King's Home Pre-Audit Questionnaire responses

Interviews:

1. Interview with Program Director
2. Interview with PREA Compliance Manager
3. Shelby County Sheriff's Department Investigator

Site Review Observations:

Observations during on-site review of physical plant

Findings (By Provision):

115.371 (a)

PAQ: The agency/facility has a policy related to criminal and administrative agency investigations.

Shelby County Sheriff's Department is responsible for allegations of sexual abuse or sexual harassment. The investigator stated once a case is received, it takes less than 24 hours to initiate an

investigation following an allegation of sexual abuse or sexual harassment. The investigator confirmed he handles anonymous or third-party reports of sexual abuse and sexual harassment in the same manner as all investigations. He begins by interviewing the individual who reported the allegation. The auditor reviewed the report for the allegation of sexual abuse and observed they were received in a timely manner.

115.371 (b)

Shelby County Sheriff's Department investigators receive specialized training in sexual abuse investigations involving juveniles. The Shelby County Sheriff's Department investigator confirmed he received training specific to conducting sexual abuse and sexual harassment investigations in confinement settings through classroom and computer-based training. He confirmed he received the required training.

115.371 (c)

The Shelby County Sheriff's Department Investigator gathers all evidence, and interviews alleged victims, suspected perpetrators, and witnesses. The investigation will include reviewing any prior complaints and reports of sexual abuse involving the suspected perpetrator. The investigator will not terminate the investigation solely because the victim recants the allegation.

The Shelby County Sheriff's Department investigator confirmed the first steps in initiating an investigation is contacting the facility where an allegation of sexual abuse or sexual harassment has been made and requesting all available information. This occurs within 24 hours. He then travels to the facility to conduct interviews with the alleged victim, alleged perpetrator, and all witnesses. Direct and circumstantial evidence he would be responsible for gathering in an investigation of an incident of sexual abuse would include interviews, statements, third-party information, etc.

115.371 (d)

PAQ: The agency does not terminate an investigation solely because the source of the allegation recants the allegation.

The Shelby County Sheriff's Department investigator confirmed an investigation does not terminate if the source of the allegation recants the allegation.

115.371 (e)

The Shelby County Sheriff's Department investigator confirmed when he discovers evidence that a prosecutable crime may have taken place, he consults with prosecutors before conducting compelled interviews.

115.371 (f)

The Shelby County Sheriff's Department investigator confirmed he judges the credibility of an alleged victim, suspect, or witness based on evidence. He stated under no circumstance, does he require a resident who alleges sexual abuse to submit to a polygraph examination or truth telling device as a condition for proceeding with an investigation.

115.371 (g)

The Shelby County Sheriff's Department investigator confirmed the efforts he makes during an administrative investigation to determine whether staff actions or failures to act contributed to the sexual abuse include investigating the allegation and coordinating with the DYS PREA Coordinator. He confirmed he documents administrative investigations in written reports. The reports include incident reports, interviews, and all available evidence.

115.371 (h)

The Shelby County Sheriff's Department investigator confirmed criminal investigations documented. There was one criminal investigation during the audit period; the outcome of the investigation is currently pending. The investigations are documented in the appropriate incident reporting section.

115.371 (i)

PAQ: Substantiated allegations of conduct that appear to be criminal are referred for prosecution. The number of sustained allegations of conduct that appear to be criminal that were referred for prosecution since the last PREA audit: Zero (0)

The Shelby County Sheriff's Department investigator confirmed cases are referred for prosecution only when there are substantiated allegations of conduct that appears to be criminal. Currently the Shelby County Sheriff's Department has one investigation of sexual abuse pending.

115.371 (j)

PAQ: The agency retains all written reports pertaining to the administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years.

DYS and Shelby County Sheriff's Department maintains all written reports pertaining to investigations of alleged sexual abuse or sexual harassment.

115.371 (k)

The Shelby County Sheriff's Department investigator confirmed an investigation continues when a staff member alleged to have committed sexual abuse or sexual harassment terminates employment prior to a completed investigation into his/her conduct.

115.371 (l)

Any State entity or Department of Justice component that conducts such investigations shall do so pursuant to the above requirements.

115.371 (m)

The Program Director and PREA Compliance Manager stated when an outside agency investigates allegations of sexual abuse, the facility remains informed of the progress of a sexual abuse investigation through the Shelby County Sheriff's Department.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding criminal and administrative agency investigations. No corrective action is required.

Standard 115.372: Evidentiary standard for administrative investigations**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report****115.372 (a)**

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. Written Policy and Procedures 1.29
2. Written Policy and Procedures 13.8.1
3. Work Rules of State Personnel
4. Written Policy and Procedures 13.8.1 *(a)-1, p. 21, s. XIII, subs. 16
5. King's Home Pre-Audit Questionnaire responses

Interview:

Interview with Shelby County Sheriff's Department Investigator

Site Review Observations:

Observations during on-site review of physical plant

Findings:

PAQ: The agency imposes a standard of a preponderance of the evidence or a lower standard of proof when determining whether allegations of sexual abuse or sexual harassment are substantiated.

Shelby County Sheriff's Department policy states a report of child abuse by the alleged perpetrator may be classified as substantiated if there is a preponderance of evidence, in light of the entire record, which substantiated the individual committed physical, severe or child sexual abuse, as defined in Alabama Code 36-14-3.

The Shelby County Sheriff's Department investigator confirmed he refers to the preponderance of the evidence to substantiate allegations of sexual abuse or sexual harassment.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding evidentiary standard for administrative investigations. No corrective action is required.

Standard 115.373: Reporting to residents

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

115.373 (a)

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

115.373 (b)

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

115.373 (c)

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

115.373 (d)

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

115.373 (e)

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

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P 007 Reporting to Juveniles Following a Sexual Assault *(a)-1 and (c)-1, pp, 1-2
2. Policy and Procedures 1.29
3. Written Policy and Procedures 13.8.1*(a)-1, p. 21, s. XIV, subss. A-C *(b)-1, p. 21, s. XIV, subss. D *(c)-1, pp. 21-22, s. XIV, subs. A and E *(e)-1, p. 21, s. XIV, subs. B
4. PREA Form 115.371 Process for Investigating Sexual Assaults
5. PREA Form 115.373 Juvenile Notification of Investigative Outcome *(a)-1
6. King's Home Pre-Audit Questionnaire responses

Interviews:

1. Interview with Program Director
2. Interview with Shelby County Sheriff's Department Investigator

3. Interview with Residents who Reported a Sexual Abuse – N/A

Site Review Observations:

Observations during on-site review of physical plant

Findings (by provision):

115.373 (a)

PAQ: The agency has a policy requiring that any resident who makes an allegation that he or she suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency.

In the past 12 months:

1. The number of criminal and/or administrative investigations of alleged resident sexual abuse that were completed by the agency/facility: Zero (0)
2. Of the investigations that were completed of alleged sexual abuse, the number of residents who were notified, verbally or in writing, of the results of the investigation: Zero (0)

Following an investigation into a resident's allegation of sexual abuse occurring in a King's Home facility, the resident will be informed as to whether the allegation has been determined to be substantiated or unsubstantiated. Such information will be requested from the investigative agency (Shelby County Sheriff's Department) in order to inform the resident.

The Program Director confirmed a resident who makes an allegation of sexual abuse is notified that the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation.

The Shelby County Sheriff's Department Investigator confirmed he is aware that when a resident makes an allegation of sexual abuse, the resident must be informed as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation.

115.373 (b)

PAQ: If an outside entity conducts such investigations, the agency requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation.

In the past 12 months:

1. The number of investigations of alleged resident sexual abuse in the facility that were completed by an outside agency: Zero (0)
2. Of the outside agency investigations of alleged sexual abuse that were completed, the number of residents alleging sexual abuse in the facility who were notified verbally or in writing of the results of the investigation: Zero (0)

Shelby County Sheriff's Department conducts administrative and criminal sexual abuse investigations. Currently an allegation of sexual abuse of resident on resident that occurred on July 1, 2020 is being investigated by the Shelby County Sheriff's Department, the outcome is pending.

115.373 (c)

PAQ: Following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency/facility subsequently informs the resident (unless the agency/facility has determined that the allegation is unfounded) whenever:

1. The staff member is no longer posted within the resident's unit;
2. The staff member is no longer employed at the facility;

3. The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or
4. The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility.

Following a resident's allegation of sexual abuse by a staff member that is investigated, determined to be substantiated and the resident is still residing in a King's Home facility, the PREA Compliance Manager will inform the resident if the staff member is no longer working at the facility, no longer employed at the facility, has been indicted on a charge related to sexual abuse within the facility or convicted on a charge related to sexual abuse within the facility. This notification will be documented on a resident contact note.

115.373 (d)

PAQ: Following a resident's allegation that he has been sexually abused by another resident in an agency facility, the agency subsequently informs the alleged victim whenever:

1. The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or
2. The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

Following a resident's allegation of sexual abuse by another resident that is investigated, determined to be substantiated and the alleged resident victim is still residing in a King's Home facility, the PREA Compliance Manager will inform the resident if the alleged abuser has been indicted on a charge related to sexual abuse within the facility or convicted on a charge related to sexual abuse within the facility. This notification will be documented on a resident contact note.

115.373 (e)

PAQ: The agency has a policy that all notifications to residents described under this standard are documented.

In the past 12 months:

1. The number of notifications to residents that were made pursuant to this standard: Zero (0)
2. The number of those notifications that were documented: Zero (0)

Notifications will be documented on a resident contact note.

115.373 (f)

An agency's obligation to report under this standard shall terminate if the resident is released from the agency's custody.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding reporting to residents. No corrective action is required.

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

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

115.376 (a)

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

115.376 (b)

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

115.376 (c)

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

115.376 (d)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.001 Protection from Sexual Abuse and Assault *(a)-1, p. 16, s. L, subbs. 1-4
2. Written Policy and Procedures 1.29 *(a)-1, p. 6, s. G, subs. 5, and s. H
3. Written Policy and Procedures 13.8.1*(a)-1, p. 1, 3 *(a)-1, p. 26-27, s. XX, subss. A-D
4. Disciplinary Sanctions for Sexual Misconduct
5. King's Home Pre-Audit Questionnaire responses

Interview:

1. Interview with Program Director

Site Review Observations:

Observations during on-site review of physical plant

Findings (by provision):

115.376 (a)

PAQ: Staff is subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

Staff shall be subject to disciplinary sanctions up to and including termination for violating King's Home sexual abuse or sexual harassment policies.

115.376 (b)

In the past 12 months:

1. The number of staff from the facility that have violated agency sexual abuse or sexual harassment policies: Zero (0)
2. The number of those staff from the facility that have been terminated (or resigned prior to termination) for violating agency sexual abuse or sexual harassment policies: Zero (0)

Termination shall be the presumptive disciplinary sanction for staff who has engaged in sexual abuse.

115.376 (c)

PAQ: Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories.

In the past 12 months, the number of staff from the facility that have been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies: Zero (0)

Disciplinary sanctions for violations of King's Home policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories.

115.376 (d)

PAQ: All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, are reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies. In the past 12 months, the number of staff from the facility that have been reported to law enforcement or licensing boards following their termination (or resignation prior to termination) for violating agency sexual abuse or sexual harassment policies: Zero (0)

All terminations for violations of King's Home sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding disciplinary sanctions for staff. No corrective action is required.

Standard 115.377: Corrective action for contractors and volunteers**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report****115.377 (a)**

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

115.377 (b)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.001 Protection from Sexual Abuse and Assault *(a)-1, p. 17-18, s. N
2. Written Policy and Procedures 13.8.1 *(a)-1, p. 28, s. XXII
3. PREA Form 115.332 Volunteer and Contractor Receipt of PREA
4. DYS Form 8.12 Critical Incident Report
5. Reports to Law Enforcement
6. King's Home Pre-Audit Questionnaire responses

Interview:

1. Interview with Program Director

Site Review Observations:

Observations during on-site review of physical plant

Findings (by provision):

115.377 (a)

PAQ: Agency policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. Agency policy requires that any contractor or volunteer who engages in sexual abuse be prohibited from contact with residents. In the past 12 months, no contractors or volunteers have been reported to law enforcement agencies and relevant licensing bodies for engaging in sexual abuse of residents.

The facilities maintain form 115.332 Volunteer and Contractor Receipt of PREA confirming that volunteers and contractors understand the training they have received. The acknowledgement form states the King's Home's zero-tolerance policy and requires that any contractor or volunteer who violates the policy will be terminated and referred for criminal prosecution unless the activity was clearly not criminal.

115.377 (b)

PAQ: The facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer.

The Program Director confirmed that any volunteer or contractor who engages in sexual abuse would be prohibited further contact with the residents pending investigation.

King's Home policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. King's Home takes appropriate remedial measures, and considers whether to prohibit further

contact with residents, in the case of any other violation of Agency sexual abuse or sexual harassment policies by a contractor or volunteer. No contractors or volunteers were reported to law enforcement agencies and relevant licensing bodies for engaging in sexual abuse of residents within the twelve-month audit period. King's Home does not have contractors or volunteers who come in contact with the residents.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding corrective action for contractors and volunteers. No corrective action is required.

Standard 115.378: Interventions and disciplinary sanctions for residents

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

115.378 (a)

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

115.378 (b)

- Are disciplinary sanctions commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories? ☒ Yes ☐ No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied daily large-muscle exercise? ☒ Yes ☐ No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident is not denied access to any legally required educational programming or special education services? ☒ Yes ☐ No
- In the event a disciplinary sanction results in the isolation of a resident, does the agency ensure the resident receives daily visits from a medical or mental health care clinician? ☒ Yes ☐ No
- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other programs and work opportunities to the extent possible? ☒ Yes ☐ No

115.378 (c)

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

115.378 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions? ☒ Yes ☐ No
- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general programming or education? ☒ Yes ☐ No

115.378 (e)

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

115.378 (f)

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

115.378 (g)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.001 Protection from Sexual Abuse and Assault *(a)-1, pp. 16-17, s. M, subbs. 1-7
2. Written Policy and Procedures 13.8.1 *(a)-1, pp. 27-28, s. XXI, subss. A-G
3. DYS Form 8.12 Critical Incident Report
4. DYS Form 8.12.1 Critical Incident Initial Debriefing
5. DYS Form 8.12.2 Critical Incident Two Week Follow-up Debriefing Report
6. Student Disciplinary Report
7. Student Disciplinary Hearing Report
8. PREA Form 115.342 Housing Unit Placement Form
9. Crisis Intervention Treatment Notes
10. PREA Form 115.371.1 Investigative Outcome
11. King's Home Pre-Audit Questionnaire responses

Interviews:

1. Interview with Program Director
2. Interview with Program Counselor

Site Review Observations:

Observations during on-site review of physical plant

Findings (by provision):

115.378 (a)

PAQ: Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse. Residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following a criminal finding of guilt for resident-on-resident sexual abuse.

In the past 12 months:

1. The number of administrative findings of resident-on-resident sexual abuse that have occurred at the facility: Zero (0)
2. The number of criminal findings of guilt for resident-on-resident sexual abuse that have occurred at the facility: Zero (0)

It is the policy of the Alabama Department of Youth Services that residents will be subject to disciplinary sanctions only pursuant to a formal disciplinary process following a criminal finding that the resident engaged in resident on resident sexual abuse/ harassment. Therapy, counseling, and case management services will be provided to address and correct the underlying reasons or motivations for abuse.

115.378 (b)

In the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, the facility policy requires that residents in isolation have daily access to large muscle exercise, legally required educational programming, and special education services. In the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, residents in isolation receive daily visits from a medical or mental health care clinician. In the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, residents in isolation have access to other programs and work opportunities to the extent possible.

In the past 12 months:

1. The number of residents placed in isolation as a disciplinary sanction for resident-on resident sexual abuse: Zero (0)
2. The number of residents placed in isolation as a disciplinary sanction for resident-on resident sexual abuse, who were denied daily access to large muscle exercise, and/or legally required educational programming, or special education services: N/A

3. The number of residents placed in isolation as a disciplinary sanction for resident-on resident sexual abuse, who were denied access to other programs and work opportunities: N/A

King's Home does not use isolation as a disciplinary sanction. The Program Director stated disciplinary sanctions would include placing youth on restriction or placement changes. The sanctions would be proportionate to the nature and circumstances of the abuses committed, the residents' disciplinary histories, and the sanctions imposed for similar offenses by other residents with similar histories. Isolation is not used as a disciplinary sanction.

115.378 (c)

The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his behavior when determining what type of sanction, if any, should be imposed.

When determining sanctions, a resident's mental disabilities or mental illness is considered when determining what type of sanction, if any, should be imposed.

The Program Director confirmed mental disability or mental illness is considered when determining sanctions.

115.378 (d)

PAQ: The facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. If the facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse, the facility considers whether to require the offending resident to participate in such interventions as a condition of access to any rewards-based behavior management system or other behavior based incentives. Access to general programming or education is not conditional on participation in such interventions.

The facility would consider whether to refer the offending resident to counseling or other interventions designed to address and correct underlying reasons motivations for abuse.

115.378 (e)

PAQ: The agency disciplines residents for sexual contact with staff only upon finding that the staff member did not consent to such contact.

Residents will be disciplined for sexual contact with staff only upon finding that the staff member did not consent to such contact.

115.378 (f)

PAQ: The agency prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.

115.378 (g)

PAQ: The agency prohibits all sexual activity between residents. The agency deems such activity to constitute sexual abuse only if it determines that the activity is coerced.

King's Home residents may be subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse.

Disciplinary sanctions are commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories. The disciplinary process considers whether a resident's mental disabilities or mental illness contributed to his behavior when determining what type of sanction, if any, should be imposed.

If the Facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the Facility would offer the offending resident participation in such interventions. The Agency does not require participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives. Participation is not required for access to general programming or education. The Director of The Office of Investigations will refer youth for criminal prosecution when appropriate. The Agency will discipline a resident for sexual contact with staff only upon finding the staff member did not consent to such contact.

Isolation is not used as a disciplinary measure for resident-on-resident sexual abuse. The Facility prohibits disciplinary action for a youth reporting sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation.

King's Home/DYS has a zero-tolerance policy toward all sexual activity between residents and may discipline residents for such activity. The Agency deems such activity to constitute sexual abuse only if it determines that the activity is coerced. King's Home does not utilize isolation. There have been no administrative or criminal findings of resident-on resident sexual abuse at the facility within the twelve month audit period.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding disciplinary sanctions for residents. No corrective action is required.

MEDICAL AND MENTAL CARE

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

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

115.381 (a)

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

115.381 (b)

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

115.381 (c)

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

115.381 (d)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.001 Protection from Sexual Abuse and Assault *(a)-1, p. 7. s. B, subs. 6
2. Written Policy and Procedures 13.8.1 *(a)-1, pp. 11-13. s. IV, subs. I
3. Code of Alabama
4. PREA Form 115.341 Intake Screening for Assaultive Behavior, Sexually Aggressive Behavior, and Risk for Sexual Victimization
5. DYS Form 115.381 Clinical Services Consent to Treatment
6. PREA Form 115.381a Release of Information

Interviews:

1. Interview with Staff Responsible for Risk Screening
2. Interview with Program Counselor
3. Interviews with Residents who Disclosed Sexual Victimization at Risk Screening - NA

Site Review Observations:

Observations during on-site review of physical plant

Findings (by provision):

115.381 (a)

PAQ: All residents at this facility who have disclosed any prior sexual victimization during a screening pursuant to §115.341 are offered a follow-up meeting with a medical or mental health practitioner. The follow-up meeting was offered within 14 days of the intake screening. Medical and mental health staff maintain secondary materials (e.g., form, log) documenting compliance with the above required services. In the past 12 months, the percent of residents who disclosed prior victimization during screening who were offered a follow up meeting with a medical or mental health practitioner: 100%

Counselor will develop treatment interventions, determine if further screenings or assessments are indicated and for youth who have experienced prior sexual victimization, the assigned therapist will begin treatment or make an outside referral within (14) fourteen days of the intake screening.

King's Home had no residents with prior victimization and/or who scored high risk on the risk screen during intake during the audit reporting period.

The Staff Responsible for Risk Screening confirmed that if screening indicates that a resident has experienced prior sexual victimization, whether in an institutional setting or in the community, a follow-up meeting is offered. He confirmed the meeting would occur within fourteen (14) days.

115.381 (b)

PAQ: All residents who have previously perpetrated sexual abuse, as indicated during the screening pursuant to § 115.341, are offered a follow-up meeting with a mental health practitioner. The follow-up meeting is offered within 14 days of the intake screening. Mental health staff maintain secondary materials (e.g., form, log) documenting compliance with the above required services. In the past 12

months, the percent of residents who previously perpetrated sexual abuse, as indicated during screening, who were offered a follow up meeting with a mental health practitioner: N/A (0 residents)

Each resident will be assigned a mental health therapist who will develop treatment interventions, determine if further screenings or assessments are indicated and for youth who have experienced prior sexual victimization, the assigned therapist will begin treatment within (14) fourteen days of the intake screening.

The Staff Responsible for Risk Screening confirmed that if screening indicates that a resident previously perpetrated sexual abuse, whether in an institutional setting or in the community, a follow-up meeting is offered. He confirmed the meeting would occur within fourteen (14) days.

115.381 (c)

PAQ: Information related to sexual victimization or abusiveness that occurred in an institutional setting is strictly limited to medical and mental health practitioners.

Any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law.

115.381 (d)

PAQ: Medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18.

The Program Counselor confirmed informed consent from residents is obtained from residents before reporting about prior sexual victimization that did not occur in an institutional setting. He stated he is a mandatory reporter. The facility does not house resident over 18 years of age.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding medical and mental health screenings, history of sexual abuse. No corrective action is required.

Standard 115.382: Access to emergency medical and mental health services

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

115.382 (a)

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

115.382 (b)

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

115.382 (c)

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

115.382 (d)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.001 Protection from Sexual Abuse and Assault *(d)-1, p. 12, s. H, subs. 2
2. Written Policy and Procedures 13.8.1 *(d)-1, p. 23, s. XVI subs. 4
3. Rape Crisis Center/ Child Advocacy Center Memorandum of Agreement
4. PREA Form 115.364 First Responder Checklist
5. PREA Form 115.331 Staff Receipt of PREA
6. PREA Form 115.321 Victim Advocate Receipt of PREA
7. PREA Form 115.382 Patient Consent to Treatment Form
8. Emergency Medical Treatment Notes
9. King's Home Pre-Audit Questionnaire responses

Interviews:

1. Interview with the Program Counselor
2. Interview with the Program Director
3. Interviews with Residents who Reported a Sexual Abuse – N/A
4. Interviews with Security Staff and Non-Security Staff First Responders

Site Review Observations:

Observations during on-site review of physical plant

Findings (by provision):**115.382 (a)**

PAQ: Resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The nature and scope of such services are determined by medical and mental health practitioners according to their professional judgment. Medical and mental health staff maintain secondary materials (e.g., form, log) documenting the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning sexually transmitted infection prophylaxis.

For those sexual abuse incidence alleged to have occurred within seventy two (72) hours, staff will offer to take the child/youth to the local emergency room for examination, collection and preservation of evidence, and treatment (without financial cost to the resident). Staff will request that the examination be performed by Sexual Assault Forensic Examiners (SAFE's) or Sexual Assault Nurse Examiners (SANE's) if possible. If SAFE's or SANE's cannot be made available, the examination can be performed by other qualified medical professionals. Program staff accompanying youth to the hospital will document efforts to provide SAFE's or SANE's. If the child/youth refuses medical treatment, document on form CS-0991 PREA Refusal of Medical Treatment that medical treatment was offered to the resident and if the offer for medical treatment was refused by the resident, or accepted by the resident but refused to be examined after arriving at the medical facility.

The Program Director ensures resident victims of sexual abuse while incarcerated shall be offered timely information and access to sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Resident victims of sexual abuse receive immediate and unimpeded access to emergency medical treatment and crisis intervention services.

The Program Counselor stated the nature and scope of these services would be determined according to her professional judgment and he would provide all services needed.

115.382 (b)

If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim and shall immediately notify the appropriate medical and mental health practitioners.

Staff were knowledgeable of their first responder duties, including how to take preliminary steps to protect a victim and immediately notifying the appropriate medical and mental health practitioners by following the First Responder Guidelines for Sexual Assault.

115.382 (c)

PAQ: Resident victims of sexual abuse while incarcerated are offered timely information about and timely access to sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Medical and mental health staff maintain secondary materials documenting the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.

The Program Counselor confirmed resident victims of sexual abuse receive timely and unimpeded access to crisis intervention services. He confirmed he would maintain secondary materials documenting the timeliness of crisis intervention services that were provided. Interviews with the Program Director and the Children's Hospital of Alabama confirmed residents are offered timely information about and timely access to sexually transmitted infections prophylaxis.

115.382 (d)

PAQ: Treatment services are provided to every victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

Treatment services are provided to victims at no financial cost. King's Home would be responsible for payment of medical and treatment expenses.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding access to emergency medical and mental health services. No corrective action is required.

Standard 115.383: Ongoing medical and mental health care for sexual abuse victims and abusers**All Yes/No Questions Must Be Answered by the Auditor to Complete the Report****115.383 (a)**

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

115.383 (b)

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

115.383 (c)

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

115.383 (d)

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

115.383 (e)

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

115.383 (f)

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

115.383 (g)

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

115.383 (h)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.001 Protection from Sexual Abuse and Assault * (a)-1, pp. 14-15, s. I, subbs. 1-4
2. Written Policy and Procedures 13.8.1 *(a)-1, pp. 23-25, s. XVI. subss. A-B
3. Medical Mental Health Records
4. Treatment Notes
5. Test Results
6. Memorandum of Understanding with CHIPS Center (Children's Hospital Intervention and Prevention Services)
7. Corporative Agreement with the Children's Hospital of Alabama
8. Mental Health Status Evaluation
9. King's Home Pre-Audit Questionnaire responses

Interviews:

1. Interview with the Program Counselor
2. Interviews with Residents who Reported a Sexual Abuse – N/A

Site Review Observations:

Observations during on-site review of physical plant

Findings (by provision):

115.383 (a)

PAQ: The facility offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.

Residents who are the victim of sexual abuse will be provided prompt and appropriate medical treatment and counseling, to include but not limited to:

1. Facility staff provides emotional support to the resident through the forensic medical exam process and investigation interviews.
2. The development of a safety plan that includes a review / adjustment (if necessary), of bed and bedroom assignments, or possible facility/placement reassignment to keep the resident safe and free from sexual abuse.
3. An assessment by a mental health professional.
4. Mental health counseling as needed considering the preferences of the resident. Services will be provided by mental health professionals with-in King's Home or an outside provider. The resident's preferences will be documented.

115.383 (b)

The evaluation and treatment of victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.

115.383 (c)

The facility provides victims with medical and mental health services consistent with the community level of care.

115.383 (d)

PAQ: Female victims of sexual abusive vaginal penetration while incarcerated are offered pregnancy tests.

115.383 (e)

PAQ: If pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services.

Information about timely access to emergency contraception, lawful pregnancy related medical services and sexually transmitted infections prophylaxis will be provided. King's Home does not house female youth.

115.383 (f)

PAQ: Resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate.

Resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections at local area hospitals.

115.383 (g)

PAQ: Treatment services are provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

King's Home provides treatment services without financial cost to victims.

115.383 (h)

PAQ: The facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate by mental health practitioners.

The Program Counselor confirmed a mental health evaluation of all known resident-on-resident abusers would be conducted and they would be offered treatment if appropriate. He stated the mental health evaluation would be offered as soon as he is notified.

The CHIPS Center (Children's Hospital Intervention and Prevention Services) shall offer medical and mental health evaluations and appropriate treatment in adherence to PREA standards. Care is consistent with the community level of care. There has been one sexual assault victims in the past 12 months.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding ongoing medical and mental health care for sexual abuse victims and abusers. No corrective action is required.

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

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

115.386 (a)

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

115.386 (b)

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

115.386 (c)

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

115.386 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d) (1) - (d) (5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.386 (e)

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

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.001 Protection from Sexual Abuse and Assault * (a)-1. pp. 18-19, s. O
2. Written Policy and Procedures 13.8.1 *(a)-1, pp. 28-29, s. XXIII, subbs. 1-7
3. Supporting Documentation:
4. DYS Form 8.12 Critical Incident Report
5. DYS Form 8.12.1 Critical Incident Initial Debriefing
6. DYS Form 8.12.2 Critical Incident Two-Week Follow-up Debriefing
7. PREA Form 115.386 Sexual Abuse Critical Incident Review
8. King's Home Pre-Audit Questionnaire responses

Interviews:

1. Interview with Program Director
2. Interview with PREA Compliance Manager
3. Interview with Incident Review Team Member

Site Review Observations:

Observations during on-site review of physical plant

Findings (by provision):

115.386 (a)

PAQ: The facility conducts a sexual abuse incident review at the conclusion of every sexual abuse criminal or administrative investigation unless the allegation has been determined to be unfounded. In the past 12 months, the number of criminal and/or administrative investigations of alleged sexual abuse completed at the facility, excluding only "unfounded" incidents: Zero (0)

A sexual Abuse Incident review will occur within 30 days of the conclusion of every sexual abuse investigation unless the incident has been determined to be unfounded.

115.386 (b)

PAQ: The facility ordinarily conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation.

In the past 12 months, the number of criminal and/or administrative investigations of alleged sexual abuse completed at the facility that were followed by a sexual abuse incident review within 30 days, excluding only "unfounded" incidents: Zero (0)

115.386 (c)

PAQ: The sexual abuse incident review team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners.

The review team will consist of management level staff present at the Alabama Department of Youth Services monthly Quality Improvement (QI) meeting. The Program Director confirmed the facility has a sexual abuse incident review team.

115.386 (d)

PAQ: The facility prepares a report of its findings from sexual abuse incident reviews, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submits such report to the facility head and PREA compliance manager.

The review team will:

1. Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect or respond to sexual abuse.
2. Consider whether the incident or allegation was motivated by:
 - Race
 - Ethnicity
 - Gender Identity
 - Lesbian, gay, bisexual, transgender (GLBT) or intersexual identification, status, or perceived status, or
 - Gang affiliation or was motivated or otherwise caused by other group dynamics at the facility.
3. Meet at the facility where the alleged incident occurred, examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse;
4. Assess the adequacy of staffing patterns during certain shifts;
5. Assess monitoring technology adequacy; and
6. Document any recommendations for improvement, or reasons for not doing so.

The Program Director and PREA Compliance Manager confirmed the PREA Incident Review Team considers whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. The area in the facility where the incident allegedly occurred is examined to assess whether physical barriers in the area may enable abuse. Adequacies of staffing levels in the area are assessed for different shifts. He confirmed the PREA Incident Review Team assesses whether monitoring technology should be deployed or augmented to supplement supervision by staff. The facility prepares a report of its findings from the review, including any determinations and any recommendations for improvement. He confirmed he is a member of the sexual abuse incident review team, other members include the Assistant Program Director (PREA Compliant Manger), and Program Counselor.

115.386 (e)

PAQ: The facility implements the recommendations for improvement or documents its reasons for not doing so.

There has been one criminal investigations of sexual abuse conducted in the last 12 months. The investigation is currently being conducted by the Shelby County Sheriff's Department, the investigation is pending.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding sexual abuse incident reviews. No corrective action is required.

Standard 115.387: Data collection

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

115.387 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

115.387 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? ☒ Yes ☐ No

115.387 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

115.387 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? ☒ Yes ☐ No

115.387 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☒ Yes ☐ No ☐ NA

115.387 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.001 Protection from Sexual Abuse and Assault * (a)-1, p. 19, ss. 1-4
2. Written Policy and Procedures 13.8.1 *(a)-1, pp. 29-30, s. XXV. subss. A-E
3. U.S. DOJ Form SSV-IJ Survey of Sexual Violence Reporting, Incident Form (Juvenile)
4. Annual Survey of Sexual Violence
5. Annual Data Review
6. King's Home Pre-Audit Questionnaire responses
7. Survey of Sexual Victimization Substantiated Incident Form (Juvenile)

Site Review Observations:

Observations during on-site review of physical plant

Findings (by provision):

115.387 (a)

PAQ: The agency collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions. The standardized instrument includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Victimization conducted by the Department of Justice.

Data will be provided to DYS as instructed by the DYS PREA Coordinator utilizing a standard instrument provided by DYS to contracted providers.

The auditor reviewed Survey of Sexual Victimization Substantiated Incident Form (Juvenile) for verification.

115.387 (b)

PAQ: The agency aggregates the incident-based sexual abuse data at least annually.

The auditor reviewed the aggregated incident-based sexual abuse data.

115.387 (c)

PAQ: The incident-based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

The Survey of Sexual Victimization Substantiated Incident Form (Juvenile) provides data necessary to answer all questions from the most recent version of the Survey of Sexual Victimization (SSV) conducted by the Department of Justice.

115.387 (d)

PAQ: The agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

DYS maintains, reviews, and collects data as needed from all available incident-based documents, including report and investigation files. King's Home maintains sexual abuse incident reviews.

115.387 (e)

The agency also shall obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents. The data from private facilities complies with SSV reporting regarding content.

King's Home does not contract with other facilities for the confinement of its residents.

115.387 (f)

Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

The DOJ did not request King's Home to provide all such data from the previous calendar year.

King's Home collects accurate, uniform data for all allegations of sexual abuse and sexual harassment using the U.S. DOJ Form SSV-IJ Survey of Sexual Violence Reporting, Incident Form (Juvenile). The Agency maintains reviews and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding data collection. No corrective action is required.

Standard 115.388: Data review for corrective action

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

115.388 (a)

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No
- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.388 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☒ Yes ☐ No

115.388 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.388 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.001 Protection from Sexual Abuse and Assault * (a)-1, pp. 18-19, s. Q, subss. 1-4
2. Written Policy and Procedures 13.8.1 *(a)-1, p. 30, s. XXVI, subss. A-D

3. DYS Form 8.12.1 Critical Incident Initial Debriefing
4. DYS Form 8.12.2 Critical Incident Two Week Follow-up Debriefing
5. Annual Data Review
6. Annual Facility PREA Report
7. Annual DYS PREA Report
8. King's Home Pre-Audit Questionnaire responses

Document (Corrective Action):

1. Annual Reports published at: <http://dys.alabama.gov>

Interviews:

1. Interview with the Agency Head Designee (PREA Compliance Coordinator)
2. Interview with the PREA Coordinator

Site Review Observations:

Observations during on-site review of physical plant

Findings (by provision):

115.388 (a)

PAQ: The agency reviews data collected and aggregated pursuant to §115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training, including:

1. Identifying problem areas;
2. Taking corrective action on an ongoing basis; and
3. Preparing an annual report of its findings from its data review and any corrective actions for each facility, as well as the agency as a whole.

Data will also be sent to 1. King's Home's Director of Quality Improvement to collect and aggregate in order to assess and improve the effectiveness of sexual abuse prevention, detection, and response to policies, practices and training including by preparing an annual report of findings and corrective actions for each facility, as well as the agency as a whole. A comparison of the current years data and corrective actions with those from prior years and shall provide an assessment of the agencies progress in addressing sexual abuse.

The Agency Head Designee/ PREA Coordinator confirmed the facility uses incident-based sexual abuse data to assess and improve sexual abuse prevention, detection, response policies, practices, and training to identify problem areas and take corrective action as needed. The agency ensures that data collected is securely retained.

115.388 (b)

PAQ: The annual report includes a comparison of the current year's data and corrective actions with those from prior years. The annual report provides an assessment of the agency's progress in addressing sexual abuse.

The auditor reviewed the annual reports for verification.

115.388 (c)

PAQ: The agency makes its annual report readily available to the public at least annually through its website. The annual reports are approved by the agency head.

The report will be approved by the agencies Performance Improvement Committee and annually by the Board of Directors and made available to the public through the web-site or other means as applicable.

The Agency Head Designee confirmed she approves annual reports.

The auditor observed the annual reports were published on the agency's website and approved by the Alabama Department of Youth Services at <http://dys.alabama.gov>.

115.388 (d)

PAQ: When the agency redacts material from an annual report for publication the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility. The agency indicates the nature of material redacted.

Specific material may be redacted from the reports when publication would present a clear and specific threat to the safety, and security of a specific facility, but will indicate the nature of the material redacted.

The PREA Coordinator stated all identifying information is redacted from the report, the auditor observed no personal identifiers were included in the annual report.

In compliance with PREA Standard §115.389, regarding publication of aggregated sexual abuse data, the Alabama Department of Youth Services (DYS)/King's Home reports no incidents of Sexual Victimization on the 2015 U.S. Department of Justice Survey of Sexual Victimization. DYS/King's Home continues to educate all staff, youth, contractors, and volunteers on PREA and the importance of protecting youth in confinement facilities from sexual abuse.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding data review for corrective action. Corrective action has been completed.

115.388 (a-d)

The agency developed an annual report according to the standard requirements. The annual reports were published at: <http://dys.alabama.gov>.

Standard 115.389: Data storage, publication, and destruction

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

115.389 (a)

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained?
☒ Yes ☐ No

115.389 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.389 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.389 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

Documents:

1. DYS-P.001 Protection from Sexual Abuse and Assault * (a)-1, s. P, subss. 1-5
2. Written Policy and Procedures 13.8.1 *(a)-1&(b)-1, pp. 30-31, s. XXVII, subs. A-D
3. Records Retention Schedule *(a)-1, p. 31, s. XXVII, subss. D
4. Annual PREA Report Published on Website King's Home PREA Policy
5. DYS Policy 18.8 Protection from Sexual Abuse and Assault
6. King's Home Pre-Audit Questionnaire responses

Document (Corrective Action):

2. Annual Reports published at: <http://dys.alabama.gov>.

Interview:

1. Agency Head Designee (Agency PREA Coordinator)
2. PREA Compliance Manager

Site Review Observations:

Observations during on-site review of physical plant

Findings (by provision):

115.389 (a)

PAQ: The agency ensures that incident-based and aggregate data are securely retained.

The PREA Coordinator confirmed the agency reviews data collected and aggregated in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training. The agency ensures that data collected is securely retained.

115.389 (b)

PAQ: Agency policy requires that aggregated sexual abuse data from facilities under its direct control and private facilities with which it contracts be made readily available to the public, at least annually, through its website.

The auditor observed the annual reports were published on the agency's website and approved by the Alabama Department of Youth Services at: <http://dys.alabama.gov>

115.389 (c)

PAQ: Before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers.

Specific material may be redacted from the reports when publication would present a clear and specific threat to the safety, and security of a specific facility, but will indicate the nature of the material redacted.

The auditor observed the annual reports were published on the agency's website. The auditor observed no personal identifiers at <http://dys.alabama.gov>.

115.389 (d)

PAQ: The agency maintains sexual abuse data sexual abuse data collected pursuant to §115.387 for at least 10 years after the date of initial collection, unless Federal, State or local law requires otherwise.

DYS and King's Home maintains sexual abuse data collected pursuant to PREA Standards §115.387 for at least ten (10) years after the date of its initial collection.

The auditor reviewed historical sexual abuse data.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding data storage, publication, and destruction. Corrective action has been completed.

115.389 (b)

The annual reports were published at: <http://dys.alabama.gov>.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

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

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note: The response here is purely informational. A "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard.*) ☒ Yes ☐ No
- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the second year of the current audit cycle.) ☐ Yes ☐ No ☒ NA
- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the third year of the current audit cycle.) ☐ Yes ☐ No ☒ NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with residents? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

1. King's Home Pre-Audit Questionnaire responses
2. Interviews
3. Research
4. Policy Review
5. Document Review
6. Observations during onsite review of facility

During the three-year period starting on August 20, 2013, and the current audit cycle, Alabama DYS ensured that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once. Also, one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited.

The auditor was given access to, and the ability to observe, all areas of the audited facility. The auditor was permitted to conduct private interviews with residents at the facility. The auditor sent an audit notice to the facility more than six weeks prior to the on-site audit. The audit notice contained contact information for the auditor. The residents were permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel. No confidential information or correspondence was received.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding frequency and scope of audits. No corrective action is required.

Standard 115.403: Audit contents and findings

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

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

- ☐ **Exceeds Standard** (*Substantially exceeds requirement of standards*)
- ☒ **Meets Standard** (*Substantial compliance; complies in all material ways with the standard for the relevant review period*)
- ☐ **Does Not Meet Standard** (*Requires Corrective Action*)

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making the compliance determination:

1. King's Home Pre-Audit Questionnaire responses
2. Policy Review
3. Documentation Review
4. Interviews
5. Observations during onsite review of facility

All King's Home Audit Reports are available for review upon request, going forward will be published on Agency's website at: <http://dys.alabama.gov>.

Corrective Action

Based upon the review and analysis of the available evidence, the auditor has determined the agency and facility is fully compliant with this standard regarding audit contents and findings.

115.403 (f)

The 2017 Final Audit Report is available upon request.

AUDITOR CERTIFICATION

I certify that:

- ☒ The contents of this report are accurate to the best of my knowledge.
- ☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- ☒ I have not included in the final report any personally identifiable information (PII) about any resident or staff member, except where the names of administrative personnel are specifically requested in the report template.

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.¹ Auditors are not permitted to submit audit reports that have been scanned.² See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Mable P. Wheeler

October 2, 2020

Auditor Signature

Date

¹ See additional instructions here: <https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110>.

² See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.