

Prison Rape Elimination Act (PREA) Audit Report Juvenile Facilities

☐ Interim ☒ Final

Date of Interim Audit Report: 7/24/2020 ☐ N/A

If no Interim Audit Report, select N/A

Date of Final Audit Report: 8/10/2020

Auditor Information

Name: Latera M. Davis	Email: laterad2@gmail.com
Company Name: Just4Consultants LLC	
Mailing Address: PO Box 1105	City, State, Zip: Grayson, GA 30017
Telephone: 404-457-8953	Date of Facility Visit: June 8-9, 2020

Agency Information

Name of Agency: The Youth Services Institute			
Governing Authority or Parent Agency (If Applicable): The University of Alabama			
Address: 1500 Greensboro Avenue, Suite 3		City, State, Zip: Tuscaloosa, Alabama 35401	
Mailing Address: PO Box 870316		City, State, Zip: Tuscaloosa, Alabama 35487	
The Agency Is:	<input type="checkbox"/> Military	<input type="checkbox"/> Private for Profit	<input type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input checked="" type="checkbox"/> State	<input type="checkbox"/> Federal
Agency Website with PREA Information: https://socialwork.ua.edu/research/youth-services-institute/wow-program			

Agency Chief Executive Officer

Name: Jill Beck	
Email: jrbeck2@ua.edu	Telephone: 205-348-2992

Agency-Wide PREA Coordinator

Name: April Jones	
Email: jones100@sw.ua.edu	Telephone: 205-534-0357
PREA Coordinator Reports to:	Number of Compliance Managers who report to the PREA Coordinator:

Jill Beck		0	
Facility Information			
Name of Facility: Working on Womanhood (WOW)/Girls Intensive Education and Treatment Facility			
Physical Address: 6001 12th Ave. E., Suite B		City, State, Zip: Tuscaloosa, Alabama 35405	
Mailing Address: PO Box 870317		City, State, Zip: Tuscaloosa, Alabama 35487	
The Facility Is:	<input type="checkbox"/> Military	<input type="checkbox"/> Private for Profit	<input type="checkbox"/> Private not for Profit
<input type="checkbox"/> Municipal	<input type="checkbox"/> County	<input checked="" type="checkbox"/> State	<input type="checkbox"/> Federal
Facility Website with PREA Information: https://socialwork.ua.edu/research/youth-services-institute/wow-program/			
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: AdvancEd, entity accrediting the educational program			
<input type="checkbox"/> N/A			
If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe: Annual and bi-annual audits by Department of Youth Services (DYS), the contracting agency for youth services; PREA Audits by DHS every 1-2 years; annual PREA assessments by PREA coordinator.			
Facility Administrator/Superintendent/Director			
Name: Dr. Jacalyn Tippey			
Email: Jackie.tippey@dys.alabama.gov		Telephone: 205-343-2880	
Facility PREA Compliance Manager			
Name: NA			
Email: NA		Telephone: NA	
Facility Health Service Administrator <input type="checkbox"/> N/A			
Name: Terri Ellis			

Email: thellis1@ua.edu		Telephone: 205-343-2878	
Facility Characteristics			
Designated Facility Capacity:		16	
Current Population of Facility:		12	
Average daily population for the past 12 months:		11	
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 checked="" type="checkbox"/> Females <input type="checkbox"/> Males <input type="checkbox"/> Both Females and Males	
Age range of population:		12-18 years old	
Average length of stay or time under supervision		190 days	
Facility security levels/resident custody levels		High/Medium-High to High	
Number of residents admitted to facility during the past 12 months			26
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 72 hours or more:			0
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for 10 days or more:			26
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 type="checkbox"/> Yes <input checked="" 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: Click or tap here to enter text. <input type="checkbox"/> N/A	
Number of staff currently employed by the facility who may have contact with residents:			47

Number of staff hired by the facility during the past 12 months who may have contact with residents:	10
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 *due to COVID-19
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.	2
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.	2
Number of single resident cells, rooms, or other enclosures:	16
Number of multiple occupancy cells, rooms, or other enclosures:	0
Number of open bay/dorm housing units:	0
Number of segregation or isolation cells or rooms (for example, administrative, disciplinary, protective custody, etc.):	2
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g. cameras, etc.)?	<input checked="" type="checkbox"/> Yes <input 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Medical and Mental Health Services and Forensic Medical Exams		
Are medical services provided on-site?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Are mental health services provided on-site?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Where are sexual assault forensic medical exams provided? Select all that apply.	<input checked="" type="checkbox"/> On-site <input checked="" type="checkbox"/> Local hospital/clinic <input type="checkbox"/> Rape Crisis Center <input checked="" type="checkbox"/> Other (please name or describe: M-F: 9am-5pm, Children's Hospital of Alabama-Birmingham (CHIPS))	
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: Click or tap here to enter text.) <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?	3	
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: Select all that apply	<input checked="" type="checkbox"/> Facility investigators <input checked="" type="checkbox"/> Agency investigators <input 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 type="checkbox"/> Local sheriff's department	

	<p><input checked="" type="checkbox"/> State police</p> <p><input type="checkbox"/> A U.S. Department of Justice component</p> <p><input type="checkbox"/> Other (please name or describe: Click or tap here to enter text.)</p> <p><input checked="" type="checkbox"/> N/A</p>
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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.

Working on Womanhood (WOW) program, part of the University of Alabama/School of Social Work/Youth Services Institute, agreed to participate in a Prison Rape Elimination Act (PREA) audit, conducted by auditor (Latera Davis) and associate (Lindsay Watson).

Site Review Location: The site review for this audit took place at the WOW program located at 6001 12th Avenue E, Suite B. The facility is in the midwestern section of the state. The audit team conducted pre-audit work prior to arrival at the facility. Pre-audit work included but was not limited to: review of the Pre-Audit Questionnaire (PAQ), documentation review on the agency secure thumb drive, email correspondence, and telephone calls.

A certified PREA audit was conducted at the WOW program located in Tuscaloosa, Alabama on 6/8/20-6/9/20. The WOW program is operated by the University of Alabama; and is contracted by the Alabama Department of Youth Services (DYS) to provide housing and treatment for the Department of Youth Services (DYS) youth. The WOW facility hereinafter may be referred to as a program. It should be noted that, for the purpose of this audit report, the female youth housed at the program will be called "residents" for the duration of the report. It should also be noted that the original audit was scheduled on 4/15/20-4/16/20; however, due to COVID-19 the audit was rescheduled.

The auditor used a triangular approach, by connecting the PREA audit documentation, on-site observation, facility walk-through, practice; and interviewed staff, residents, and local and national advocates to make determinations for each standard.

Pre-onsite Audit Phase

Posting: On 2/4/2020, the auditor provided the audit notice to the WOW program PREA coordinator, with instruction to post the required PREA Audit Notice of the upcoming audit prior to the audit for confidential communications. Photos were sent to the auditor on 4/15/2020 and 4/16/2020, indicating that the facility posted the updated notices in English and Spanish. The auditor received photos of the timestamp posted notices, located in common areas. Due to COVID-19, and the rescheduling of the original audit date, the WOW program updated the notice to residents on 5/19/2020. The auditor did not receive communication from any residents.

Pre-Audit Questionnaire (PAQ): In order to prepare for the audit process, pre-kick off email correspondence occurred with the agency's PREA Coordinator (April Jones) on 2/4/2020. As the auditor reviewed the materials provided by the facility, any outstanding documents were communicated directly with the agency PREA coordinator. Completed documents were submitted or discussed via telephonic and email correspondence.

The Pre-Audit Questionnaire was completed and sent to the auditor as required. The completed Pre-Audit Questionnaire (PAQ) was submitted on 3/14/2020. Additional documentation received included agency policies, procedures, forms, education materials, training curriculum, organizational charts, posters, brochures and other PREA related materials. The lead auditor in consultation with the audit team reviewed all the documentation submitted by the facility and prepared a list of issues based on the evidence provided. Any pre-audit issues were directly discussed with the PREA coordinator.

The auditor completed a documentation review using the Pre-Audit Questionnaire, internet search, policies and procedures review, and additional documentation provided on the secure thumb drive; to include both the agency and the program policy and procedures, agency mission statement, daily population report, schematic/layout for the program, and the last final PREA Audit Report. The auditor was provided a list of requested documents for onsite review. As the auditor reviewed the materials provided by the program, the content/documents were organized and any outstanding issues/concerns were addressed via telephonic and email correspondence, with the agency PREA coordinator. It should be noted that a list of random and special categorized residents was provided prior to the onsite review.

Website Review: Prior to the onsite portion of the audit, the auditor conducted a website review of the WOW program. The reviewed content included but was not limited to: PREA website (overview and reporting), prior PREA audits, and the number of allegations received. As indicated on the website, the full report can be located upon request.

Site Review Preparation: Due to Covid-19, the site preparation process occurred over an extended period of time. The original audit was rescheduled. Between February-May 2020, the auditor provided the PREA coordinator with email notification regarding the team's upcoming site visit. A conference call was conducted on 2/13/2020 at 1:00PM EST enabling the auditor to interact with the agency PREA coordinator. The audit process was discussed as well as specific plans for the WOW program onsite audit.

Prior to the onsite portion of the audit, the auditor was made aware that the facility did not house male residents or residents who were held for immigration purposes. Email communication was sent to the PREA coordinator requesting the following information in preparation for the site review:

- Staffing Plan/Documentation of deviation for the staffing plan
- Annual Reviews
- Logs of exigent circumstances for cross gender pat down searches
- Staff training logs
- Written materials used for effective communication about PREA for residents w/disabilities or limited reading skills
- Documentation of staff training on PREA complaint practices for residents w/disabilities
- Documentation of investigators who have completed specialized investigative training
- Documentation of MH and Medical staff that have completed specialized training
- Screening instrument used to determine risk for victimization
- Documentation of use of screening information to inform housing, bed, work, education and program assignments, with the goal of keeping separate those residents with a high risk of being sexually abusive
- Sample resident grievances (onsite will review general grievances filed)
- Resident handbook (onsite will review)
- Documentation of notifications of abuse while confined at another facility (if applicable)
- Facility institutional plan (coordinated plan)

- Retaliation reports (all investigation files, last 12 months)
- Documentation when segregated housing was used to house residents who have alleged to have suffered sexual abuse (if applicable)
- Sample of investigations of alleged sexual abuse complaints completed by the agency
- Sample of investigations of alleged sexual abuse complaints completed by outside agency
- Sample of documentation of any substantiated or unsubstantiated complaints
- Sample of documentation of notifications
- Sample records of terminations, resignations, or other sanctions against staff—allegations of sexual abuse or sexual harassment - within the last 12 months – may request to review more sexual harassment records while on site)
- Reports of sexual abuse of residents by contractors or volunteers
- Sample records of disciplinary actions against residents for sexual conduct with staff
- Sample records of disciplinary actions against residents for sexual conduct against other residents (need substantiated abuse or harassment allegations)
- Documentation of sexual abuse incident reviews
- Sexual abuse reports
- Incident Mapping Report
- Unannounced Rounds Documentation
- A summary of all incidents within the past 12 months (log)
- All Transgender evaluations completed in the last 12 months
- Rosters
- Resident
- Notice of auditor post-English/Spanish (received)
- Residents w/disabilities
- Residents who are limited English proficient (LEP)
- LGBTI residents
- Residents in segregated housing (PREA related)
- Residents who reported sexual abuse
- Residents who reported sexual victimization during risk screening
- Staff Roster
- Specialized staff list
- Staff Personnel (Documentation)
- Resident Documentations
- List of contractors who have contact with residents
- List of volunteers who have contact with residents
- PREA Reassessments (all sexual abuse cases)

On-Site Audit Phase

Team Composition/Entrance

The audit team consisted of the auditor (Latera Davis) and associate (Lindsay Watson). On 6/8/2020 at approximately 8:30 am. The audit team arrived at the facility to conduct an entrance meeting with the facility director, PREA coordinator and her leadership team, along with beginning the onsite process (physical plant inspection and interviews). The leadership team consisted of Dr. Jacalyn Tippey, Facility Director, April Jones, Agency PREA Coordinator, and two additional program administrators.

Entrance Meeting

The entrance meeting served as initial introductions and onsite logistics with the program leadership. The auditor reiterated the PREA Resource Center expectations of the onsite and written report along with the audit goals. The auditor provided an overview of the expectations during the onsite audit and transparency to discuss any identified issues or concerns. The team also established a process to make corrections on site and if necessary, a post onsite follow up.

Prior to the onsite audit and upon conclusion of the entrance meeting, the audit members were provided resident and employee documentation to review. Resident and staffing lists were also provided allowing the audit team to make randomized selection of interview participants. The WOW program direct care staff work eight-hour shifts during the weekdays and twelve-hour shifts during the weekend.

Day One: The audit team conducted the physical plant site inspection along with staff and resident interviews.

Day Two: The audit team completed the remaining interviews and file review. Upon completion of assigned tasks, audit team members returned to the assigned office to discuss site observation, informal and formal interviews, file review, and necessary corrective actions. Day two also served as the close out conference.

Interviews: Due to Covid-19, and the need to take extra safety precautionary measures, resident and informal auditor contact during the walk-through was limited.

For the formal interviews, members of the audit team selected names of individuals who would be interviewed, and the facility staff prepared the residents and staff members for interview in a staged manner. Appropriate PREA-interview protocols were utilized, and standard advisory statements were communicated. The interviewing audit team members recorded responses by hand or typed. Due to the number of residents housed at the program, all residents were interviewed.

On the first day of the onsite audit there were eight residents and 25 staff reported at the program. Staff interviews were based on who was at the program on the days of the audit, varying staff shifts, and positions/roles held. The audit team members split up the interviews of specialized and random staff along with required resident interviews.

Over the two days onsite, 52 interviews were conducted with staff that have specialized roles and responsibilities. It should be noted that this also included staff that have dual role responsibilities. The interviews were conducted privately in several different meeting rooms and the protocols used included but were not limited to: contractors, incident review team members, mental health staff, screening staff, security first responders, investigators, agency head, staff who supervise residents in isolation, agency contract administrator, DYS contractor administrator, HR administrator, intake staff, PREA coordinator, intermediate or higher level staff, facility director, medical staff, staff who monitor for retaliation, one contractor and two volunteers. The WOW program has approved volunteers, however, due to COVID 19 volunteers are not allowed in the program at this time.

Along with the specialized staff, 12 random staff were interviewed. Random staff were chosen by retrieving a list of staff, choosing staff from every shift, including new and more tenured staff. A separate list of targeted residents was provided prior to the onsite audit. A total of 10 targeted residents interviews were identified. There were no residents housed for the sole purpose of immigration. It was also reported that there no residents segregated for risk of sexual victimization, which was confirmed through staff and resident interviews, as well as site review by audit team members.

The lead auditor was largely responsible for the interviews with the WOW management staff, including the director and the PREA coordinator. The audit team worked with the program to make the interview times most conducive to manage routine scheduling needs. The interviews were conducted primarily in empty offices or staff offices, via Zoom and telephonic communication.

Due to the limited number of youths housed at the program, all residents were interviewed. The sampling strategy included interviewing all residents which included selection of targeted residents within the sample of participants. Interviews were conducted using the Department of Justice (DOJ) protocols to assess the resident's knowledge of PREA and reporting mechanisms available to them at the WOW program. It should also be noted that a majority of the targeted residents at the program also reported having a history of prior victimization during risk screening. All identified lesbian, gay, or bisexual residents were interviewed.

Category of Residents	Number of Interviews
Random Residents	8
Targeted Residents	10
Total Residents Interviewed	18 ***duplication interviewed
Breakdown of Targeted Residents Interviewed	
Residents with Disabilities	0
Residents Who Are Blind, Deaf, Or Hard of Hearing (0)	0
Residents Who Are LEP	0
Residents with Cognitive Disabilities	0
Residents Who Are LGB	3
Residents Who Identify as Transgender or Intersex	0
Residents Who Reported Sexual Abuse That Occurred at The Facility (0)	0
Residents Who Reported Sexual Victimization During Risk Screening (7)	7
Resident Segregated Housing for Sexual Victimization (0)	0
Category of Staff Interviewed *** It Should Be Noted That Some Interviews Conducted Duplication of The Same Staff.	
Random Staff	12
Specialized Staff	36
Agency Head	1
Program Director	1
PREA Coordinator	1
Program Director	1
Total Staff Interviewed	52
Breakdown of Specialized Staff	
Contract Administrator	2
Intermediate or Higher-Level Staff Responsible for Conducting and Documenting Unannounced Rounds	2
Medical Staff	2
Mental Health Staff	3
Non-Medical Staff Involved in Cross Gender Searches (If Applicable)	NA

Volunteers Who Have Contact with Residents	2
Contractors Who Have Contact Residents	1
Administrative Investigators	2
Staff Who Perform Risk for Victimization and Abusiveness	2
Staff Who Screen Resident in Segregated Housing	NA
Designated Staff Members Charged with Monitoring for Retaliation	1
First Responders	12
DYS Advocate	1
Incident Review Team	5
HR Administrator	1

Site Review: The audit team conducted a comprehensive site review of the program. The audit team was provided a layout of the program prior to the onsite review. The WOW program is comprised of two buildings, in which there are two housing units in one building. The facility site visit included visiting all locations where residents had access onsite and could be present. The director, PREA coordinator, along with WOW program managers, assisted in escorting the auditor throughout the program during the inspection.

During the site review, the team members inspected the following:

- One administration building
- One resident services building

The WOW program is a medium/high secure facility for female juvenile offenders in the State of Alabama. As identified by the facility and observed during the site review, the housing unit contained two resident housing units with 16 single resident cells. All youth were housed in one unit during the time of the audit.

The auditor inspected facility doors, restrooms, and office areas. The areas were consistently secured and locked. The auditor noted placement and coverage of video monitoring and technology, along with surveillance cameras, and reviewed for potential blind spots. Inspections of bathroom and shower areas were conducted, with particular observation of possible cross-gender viewing. When reviewing the video camera system, there were no cameras that have direct viewing of the resident's toilets. Youth are housed in single cell rooms with two rooms having in cell toilet and sinks.

The living units have two community toilets and showers available for resident use. At the time of the site tour, only one housing using was being occupied. Resident shower by themselves and male staff are not allowed on the unit during shower time. The housing units open up to a multipurpose room with tables for activities or dining; and have an area with couches and chairs for groups or television. During the time of the site visit, the auditor observed residents conducting indoor recreation and a variety of group activities in the dayroom.

The residents do not have phone access on the housing unit. During the tour, the auditor noticed placement of the PREA audit notices along with the Alabama Youth Services posters and PREA informational resources. The residents were not on the unit during the onsite visit; therefore, the auditor did not observe how male staff enter the housing units.

The WOW program has two classrooms used during the school day. The classrooms are open and visually accessible to the dayroom. The classrooms may be used outside of education for groups, visitation, meetings and/or activities. Each classroom has Promethean boards, desktop computers, teacher desks, books, and a variety of educational material.

Adjacent to the dayroom are counselor offices. The dayroom serves as the center point for residential housing areas and programming. Medical care is provided to residents through the onsite medical clinic. Meals are provided by Tuscaloosa County Detention Center; which is connected to the WOW program. The WOW program is allowed to utilize the detention center gym. The WOW program has an outdoor recreation area that had an enhanced camera system installed since the last PREA audit.

Due to no new intakes, the audit team was not able to observe a portion of the resident intake/orientation process. The auditor was provided unimpeded access to all parts of the facility and all secure rooms and storage areas in the facility. There were no locations of concern identified during the tour.

The PREA audit requires the auditor to conduct outreach to relevant national and local advocacy organizations and to communicate with community-based or victim advocates who may have insight into relevant conditions in the facility. The following national advocacy, State, and/or community advocacy organizations were contacted.

Advocacy Organization	Date Received
Just Detention International (JDI)	7/30/2020
Rape, Abuse & Incest National Network (RAINN)	7/30/2020
Sexual Assault Nurse Examiner (SANE) Crisis Center (CHIPS)	7/31/2020

The auditor asks the advocacy organizations the following questions:

How many SAFE or SANE referrals were made in the last 12 months?

Can the resident remain anonymous, upon request, when making a report?

Who do you notify at the facility regarding the report?

How many reports has the organization received in the past 12 months for advocacy services?

How many residents reported sexual abuse and/or sexual harassment?

It should also be noted that the Alabama DYS has an internal advocacy program; in which the DYS staff will accept allegations of sexual abuse or harassment, monitor said claims, and follow up with the resident.

Documentation Review and Sampling

Documents Reviews: During the site review, documentation review included but was not limited to the audit team's review of: personnel files, training records, resident intake, screening, and education records; along with sexual abuse/harassment investigations, grievances and any other related

documents that covered the prior 12-month period. The documentation review process was covered by the auditor.

Records Review		
Name of record	Total # of records	# sampled and reviewed
Staff personnel records	49	25
Volunteers and contractor personnel record	19	11
Training files/documentation/records (staff, contractor, volunteer)	19	11
Medical/mental health records (victims)	0	0
Resident contact after report SH/SA and intake screening		
Intake files (resident education/SVAT)	26	31
***Records of youth placed after the start of audit reviewed as well.		
PREA Grievance Forms	1	1
Investigation Records	11	11

Investigation Records

	Sexual Abuse		Sexual Harassment	
	Resident on Resident	Staff on Resident	Resident on Resident	Staff on Resident
Hotline	0	0	0	0
Grievances	1	0	0	0
Anonymous, 3 rd . party	0	0	0	1
Reports by Staff	4	1	4	1

***It should be noted that the one staff on resident sexual harassment case involves "boundaries".

Grievances: The WOW program has a DYS grievance box where residents can place grievances. The grievances submitted in the DYS box are reviewed by a DYS advocate.

Informational Consolidation: The audit team members met frequently throughout the two days to consolidate information and ensure that the interviews, documentation reviews, and program observations supported a compliance determination for the required PREA standards. The team met onsite and offsite to discuss findings. When additional information was requested to establish compliance, the management team was responsive and made every effort to deliver documentation. The program staff was receptive to providing additional documentation along with noted concerns in documentation review.

Exit Briefing

The audit team conducted an exit meeting on 6/9/2019 at which preliminary findings of the review were discussed with the program leadership team. During the exit, the auditor provided an overview of the onsite inspection results and there was discussion of follow up requested information.

Post On-site Audit Phase

Upon return from the onsite phase of the audit, the auditor and the agency PREA coordinator agreed to communication by email and telephone during the post-audit phase, regarding any identified need for additional documentation, as well as clarification of questions that arose while collating data.

Communication with the WOW PREA coordinator and designated facility staff began immediately upon the conclusion of the onsite audit. Communication was ongoing, with efficient, timely, and thorough responses provided consistently both by email and telephone. Documentation and clarification emails facilitated the ability to process both the Interim and Final Reports.

Audit Section of the Compliance Tool: The auditor continued to review documentation and interview notes gathered while onsite and compile information to enter into the audit portion of the compliance tool. Detailed information from the audit interviews were integrated into relevant sections of the standards. In order to ensure all standards were thoroughly analyzed, the auditor proceeded standard by standard, determining compliance or non-compliance.

Interim Audit Report: The auditor completed entry of data into and determination of standard compliance on the Audit Compliance Tool, and began writing of the Interim Report. The Interim Report included references to policies and procedures, agency and facility reports, and supplementary documentation provided by the facility during the site review, supporting information gathered during site review, as well as aggregated and de-identified information regarding interviews conducted for the purposes of this audit. The auditor incorporated evidence gathered onsite and thorough documentation review as proof for the final conclusion of whether the facility exceeded, met, or did not meet the standard of review.

Upon submission of the Interim Report the facility was assessed to have exceeded seven standards, met 36 standards, and required corrective action for two standards. Corrective actions were made prior to the final report. Final results: seven Exceeds and 36 Met Standards.

Final Audit Report: 8/10/20

Facility Characteristics

The auditor's description of the audited facility should include details about the facility type, demographics and size of the resident, 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.

Facility Demographics:

- Rated Capacity: 16 *as indicated by the DYS Contract
- Actual Population on First Day: 12
- Average Daily Population for the last 12 months: 11
- Security/Custody Level: High/Medium-High/High
- Gender: Female
- General Medical Services: Onsite
- Mental Health Services: Onsite
- Number of staff hired by the facility in the last 12 months who may have contact with residents: 10
- Number of Positions: 49
 - o Care Worker FT- 18
 - o Care Worker PT- 7
 - o Care Worker Contingent On-Call - 8
 - o Direct Care Supervisor - 4
 - o Care Manager - 1
 - o Office Associate - 1
 - o Therapist - 2
 - o Admin - 2
 - o Nurse Supervisor - 1
 - o Nurses - 3
 - o Volunteers - 16 ***services not functioning at this time due to COVID-19
 - o Contractors - 3 ***services not functioning at this time due to COVID-19

Facility Description

The WOW program is a juvenile facility that houses female offenders in the State of Alabama. The programs mission is:

“To support the Mission of the Alabama Department of Youth Services (DYS) by facilitating holistic development of female juvenile offenders through mechanisms that reduce at-risk behaviors, values the female perspective, and recognizes the social context that encompasses the developmental needs of female offender. The WOW program provides a continuum of care that responds to female delinquency in ways that nurture healthy relationships among students, staff, and the community.”

In 2006, the Alabama Department of Youth Services (DYS), under the leadership of Mr. J. Walter Wood, Jr., identified a need to enhance the quality and effectiveness of treatment programming for female juvenile offenders in Alabama. In response to this need, Dr. Raymond O. Sumrall, Director of the Youth Services Institute (YSI) and Associate Professor in the University of Alabama (UA) School of Social Work during this period, initiated collaborations with various colleges at the University of Alabama. The

departments were chosen based on the needs of the proposed population and the clinical expertise of the selected partners. In November 2007, DYS, YSI, and UA partners met to brainstorm ideas regarding the types of holistic services needed for this population. The multidisciplinary collaboration efforts led to the development of a holistic treatment program for female offenders, entitled the Working on Womanhood (WOW) program located in the Girls Intensive Education and Treatment Facility.

The WOW program is an intervention-based program that provides services to a specialized population of adolescent females, generally between the ages of 13-18, who have been committed to the Alabama Department of Youth Services. The program is designed to provide gender specific, outcome driven interventions for adolescent females with a history of delinquent behaviors and mental health related issues.

Security Supervision

The WOW program maintains a ratio of 1:4 (student/staff) during waking hours and 1:8 during sleeping hours.

Program Model

Services include but are not limited to:

- Assessments
- ISP/IEP development
- Psychiatric services
- Medical services
- Individual/group/family counseling
- Family visitation
- Basic living skills training
- Physical education
- Vocational preparation
- Reentry (community transition)

The Evergreen School provides educational program instruction to help youth meet the requirements for high school graduation or GED. Each youth's educational experience is tailored to meet his or her specific needs. Program instruction is provided by highly qualified teachers and course objectives are taken from the Alabama Course of Study. Classroom teachers and staff are available to assist youth with lessons, activities, labs, etc.

If a youth is working towards completing a High School Diploma, they will be taking courses on ACCESS. Program highlights include:

- Work from a textbook may be given if needed, and all assignments will correlate with the ACCESS course work.
- The number of ACCESS courses taken will be determined by the WOW Lead Teacher.
- The number of ACCESS courses completed with a passing grade will determine how many credits are earned.
- Physical Education (PE) is part of the Evergreen School academic calendar and is required daily. Passing grades for PE may count towards a standard credit or an elective credit. All final credits will be determined by the WOW Lead Teacher.

The Evergreen School offers a GED program through Shelton State Community College. In order to obtain a GED, youth must be at least 17 years old and withdrawn from school. If a youth is court ordered by the juvenile court judge to obtain their GED, the program will abide by the court ruling. GED Program highlights:

- Youth work with a GED Coach from Shelton State to complete an evaluation to determine the appropriate grade level and monitor progress.
- Practice modules based on grade level are provided on computer.
- A minimum of 30 clock hours must be accumulated on the modules before the GED coach will test.
- Youth are required to complete essays and practice tests.
- A representative from Shelton State will come to the Evergreen School to administer the test.
- The Evergreen School has GED Practice Books available in the classroom for youth to work from if additional practice is needed.

In addition to educational services, the WOW program has a volunteer program, where volunteers can serve as Mentors in the following areas:

- Educational Tutor
- Individual youth sponsor
- Group sponsor
- Program activities sponsor
- Chaplain/religious service providers

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: 7

List of Standards Exceeded:

- 115.312 Contracting with other entities for the confinement of residents
- 115.313 Supervision and monitoring
- 115.318 Upgrades to facilities and technologies
- 115.333 Resident education
- 115.341 Obtaining information from residents
- 115.351 Resident reporting
- 115.381 Medical and mental health screenings: history of sexual abuse

Standards Met

Number of Standards Met: 36

Prevention and Planning

- 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
- 115.315 Limits to cross-gender viewing and searches
- 115.316 Residents with disabilities and inmates who are limited English proficient
- 115.317 Hiring and promotion decisions

Responsive Planning

- 115.321 Evidence protocol and forensic medical examination
- 115.322 Policies to ensure referrals of allegations for investigation

Training and Education

- 115.331 Employee Training
- 115.332 Volunteer and contractor training
- 115.334 Specialized training: Investigations
- 115.335 Specialized training: Medical and mental health care

Screening and Risk of Sexual Victimization and Abusiveness

- 115.342 Placement of residents in housing, bed, program, education, and work assignments

Reporting

- 115.352 Exhaustion of administrative remedies
- 115.353 Resident access to outside confidential support services
- 115.354 Third-party reporting

Official Response Following a Resident Report

- 115.361 Staff and agency reporting duties
- 115.362 Agency protection duties
- 115.363 Reporting to other confinement facilities
- 115.364 Staff first responder duties
- 115.365 Coordinated response
- 115.366 Preservation of ability to protect residents from contact with abusers
- 115.367 Agency protection against retaliation
- 115.368 Post-allegation protective custody

Investigation

- 115.371 Criminal and administrative agency investigations
- 115.372 Evidentiary standard for administrative investigations
- 115.373 Reporting to residents

Discipline

- 115.376 Disciplinary sanctions for staff
- 115.377 Corrective action for contractors and volunteers
- 115.378 Disciplinary sanctions for residents

Medical and Mental Care

- 115.382 Access to emergency medical and mental health services
- 115.383 Ongoing medical and mental health care for sexual abuse victims and abusers

Data Collection and Review

- 115.386 Sexual abuse incident reviews
- 115.387 Data collection
- 115.388 Data review for corrective action
- 115.389 Data storage, publication, and destruction

Audits and Corrective Action

- 115.401 Frequency and scope of audits
- 115.403 Audit content and findings

Standards Not Met

Number of Standards Not Met: 0
List of Standards Not Met: N/A

Seven standards exceeded compliance requirements. Thirty-six standards demonstrated substantial compliance and complied in all material ways with the standards for the relevant review period. There were two standard provision that required corrective action in order to come into compliance prior to closure of the current audit. There is a total of 43 standards for juvenile facilities.

Summary of Corrective Action if any:

While the standard of practice was exhibited, how the practice was documented and retained required corrective action. Said actions were corrected prior to the final audit.

115.373 Reporting to Residents

The initial review did not have documented instances of all notifications of the outcomes of a PREA related investigation. Upon review and discussion with the WOW program a corrective action was implemented, so that the WOW program will utilize a form to document all notifications of PREA related investigations.

No further corrective action is recommended for this standard.

115.386 Sexual Abuse Incident Reviews

It is recommended the facility either enhance the PREA Response Team form to include all of the areas that should be taken into consideration; or specify if said areas are addressed by the PREA Response Team. Corrective action was made and the WOW program has implemented the PREA Investigation Outcome/Review/Monitoring Form to ensure that all outcomes of investigations are properly documented. Hence the program has met the requirements of the standard.

No further corrective action is recommended for this standard.

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 compliance determination:

1. Documents: (Policies, directives, forms, files, records, etc.)
 - a. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - b. The University of Alabama, *Child Abuse Reporting Policy and Procedure*
 - c. WOW organizational chart
 - d. YSI organizational chart
 - e. WOW PREA coordinator appointment
 - f. Pre-Audit Questionnaire (PAQ)
2. Interviews:
 - a. PREA coordinator
 - b. Agency contract administrator
 - c. WOW program director

Findings (By Provision):

115.311 (a). The WOW program is governed by the University of Alabama School of Social Work and serves as a contracted facility for the Alabama Division of Youth Services (DYS). The WOW program has policies and standards promulgated by DYS policy that governs its program. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), pages 2 of 31, states that the "The Alabama Department of Youth Services, in compliance with the Prison Rape Elimination Act of 2003, has established a zero tolerance for incidents of Resident Sexual Abuse and Assault, Rape or Sexual Harassment in any DYS or contract service provider facilities". The policy further states that "regulatory guidelines outline how the WOW program plans to comply with DYS policy and implement the Agency's approach to preventing, detecting, and responding to allegations and incidents of sexual misconduct". Additionally, the University of Alabama, *Child Abuse Reporting Policy and Procedure* further clarifies the organizations commitment to operate a working environment free of child abuse.

According to the PAQ, the WOW program, reported that 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 contact. The facility reported having a policy outlining how it will implement the agencies approach to prevent, detect, and respond to sexual abuse and sexual harassment. The agencies policies include definitions of prohibited behaviors regarding sexual abuse and sexual harassment.

The auditor interviewed the DYS contract monitor. The contract monitor confirmed the above standards and requirements of the WOW program.

A review of the appropriate documentation, interviews with appropriate staff, and review of relevant policies, indicates that the facility follows the provisions of this standard. No corrective action is warranted.

115.311 (b). The WOW program employs an upper level, agency wide PREA Coordinator, April Jones. According to the WOW and the YSI organizational chart, the PREA coordinator reports to the YSI director.

The WOW program is an umbrella program under YSI. The PREA coordinator does not supervise any PREA compliance managers. Due to the facility structure there are no designated PREA compliance managers. The PREA coordinator, is a full-time position, responsible for the development, implementation, and oversight of PREA standards at all the assigned facilities. Regular interactions occur via email, conducting training via classroom, or webinar.

As indicated in the PAQ, the PREA coordinator indicated that she has sufficient time to develop, implement, and oversee agency efforts to comply with the PREA standards in the WOW program. It should be noted that the responsibilities of the role of the PREA coordinator are completed as required by the standard.

A review of the appropriate documentation, interviews with appropriate staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.311 (c). According to the PAQ, the WOW program does not have a designated PREA compliance manager. The WOW program does not operate more than one facility/program; therefore, there is not a designated PREA compliance manager. A memo provided by the University of Alabama School of Social Work (dated 2/19/2013), indicated that April Jones was appointed and designated as the PREA coordinator for the WOW program, effective 8/14/2012. Ms. Jones serves in both capacities as the PREA coordinator and PREA compliance manager.

The WOW program provided an organizational chart that outlines the setup of the organization.

A review of the appropriate documentation, interviews with appropriate staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents: (Policies, directives, forms, files, records, etc.):
 - a. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - b. Pre-Audit Questionnaire (PAQ)
 - c. Intergovernmental Agreement (Alabama DYS and the University of Alabama)
2. Interviews:
 - a. Agency contract administer
 - b. DYS contract monitor

Findings (By Provision):

115.312 (a). The WOW program is a contracted facility by the Alabama Department of Youth Services. The WOW program does not have the authority to contract with other entities for the confinement of. It should be noted that Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 2), "requires that as a DYS contract service provider, the WOW program plans to comply with the DYS policy and implement the agency's approach to preventing, detecting, and responding to allegations and incidents of sexual misconduct". The Pre-Audit Questionnaire (PAQ) indicated that the agency has entered into zero contracts since the last PREA audit; conducted 7/25/2017.

The Pre-Audit Questionnaire (PAQ) indicated that the agency has not entered into any contracts since the last PREA audit; conducted 7/25/17.

A review of the appropriate documentation, interviews with appropriate staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.312 (b). The WOW program is a contracted entity of the Alabama Division of Youth Services (DYS). The auditor interviewed the DYS contract monitor and it was reported that DYS monitors the program, to include the requirements of the PREA standards. The monitoring practices include but are not limited to: review of incident reports, follow up with the WOW PREA coordinator on incident findings, review follow up services (i.e. follow up with therapist), and review allegations of sexual abuse or sexual harassment. Site visits occur two times per month. During those site visits, DYS will review for clinical care documentation, observations, direct conversation with youth, and clinical file review.

The auditor interviewed the DYS contractor administrator. The DYS contract administrator reported they are responsible for monitoring the WOW program. In the event of a PREA allegation, the WOW program will send the incident reports and the DYS contract administrator will follow up with the PREA coordinator on the findings and will ensure that the resident has had follow up with the therapist. Most of the claims are of sexual harassment. The DYS contract administrator will conduct site visits two times per month; reviewing for clinical care, cleanliness and repairs. Observations are made by talking to youth who have made any allegations and they will check files for clinical review and case planning.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents: (Policies, directives, forms, files, records, etc.):
 - a. WOW program Staffing Plan (dated 1/22/2020)
 - c. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - c. Supervision Monitoring Log/Unannounced Rounds -12
 - d. Staffing outline - 5
2. Interviews:
 - a. WOW program director
 - b. PREA coordinator
 - c. Intermediate or higher-level staff - 2

Findings (By Provision):

115.313 (a). The facility indicated in their responses to the Pre-Audit Questionnaire that the agency ensures that each facility it operates develops, implements, and documents a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. In calculating these adequate staffing levels and determining the need for video monitoring, facilities shall take into consideration all relevant factors. It further indicated that the average daily number of residents since the last PREA audit is 12. Additionally, the average daily number of residents in which the staffing plan was predicted is 12. The WOW program provided policies, annual staffing plans, memos, annual reports, unannounced rounds reports, and shift rosters as documentation; showing that a staffing plan is being utilized as developed.

Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), states that the WOW program "will develop, implement, and maintain a staffing plan that provides staffing at staff/resident ratios during Resident waking hours and 1:8 during Resident sleeping hours; thus exceeding PREA standards". It further states that any deviations and exigent circumstances will be documented. The policy governs that the annual plan must be reviewed annually. Upon review of the

Annual Staffing Plan dated 1/22/2020, the WOW program takes into consideration the following:

- Generally accepted juvenile detention and correctional/secure residential practices.
- Applicable state or local laws, regulations, or standards.
- Judicial findings of inadequacy.
- Federal findings of inadequacy.
- Composition of youth population.
- Shift programming.
- Prevalence of substantiated incidents of sexual abuse.
- Facility blind spots or isolation.
- Composition of the resident population.
- Number and placement of supervisory staff.
- Institution programs occurring on a particular shift.
- The need for video monitoring.

According to interviews with the director and PREA coordinator, the facility regularly develops a staffing plan and said plan is documented. The plan assessing the following:

- a. Adequate staffing levels and
- b. Video monitoring

The program director further reiterated that the above-mentioned areas are considered when assessing adequate staffing plans. The director also reported that she checks for compliance with the staffing plans completing weekly schedules, random checks, camera review; and assigns a designated leader for shift changes. If there is ever an issue with meeting the program ratio of 1:4 and 1:8, the program will conduct hold overs with staff. Additionally, it should be noted that the PREA coordinator reported that the programs staffing ratios exceed the standards of PREA. Two intermediate or higher-level staff members were interviewed, and reported unannounced rounds are conducted and documented. The unannounced rounds are conducted at random times during various shifts. Staff have also been informed that they are not permitted to alert other staff of random visits.

The WOW program currently has 49 positions assigned to its manning table, 38 care worker staff, one office associate, two therapists, four medical staff, two administration staff, and two teachers. According to the staffing plan, three part-time positions and one full-time position was recently converted into three full-time positions, in efforts to improve stability of weekend shifts.

A review of the appropriate documentation, interviews with appropriate staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.313 (b). According to the PAQ the WOW program has not deviated from the staffing plan. The WOW program operates a staffing plan that exceeds the PREA ratio standards. The current staffing ratios for the WOW program is 1:4 waking hours and 1:8 sleeping hours.

The WOW program provided documentation of the staffing shift/roster. The staffing plan covers three shifts for the weekday and weekends: along with the supervisor on duty. There were five months of staffing outlines reviewed. The interviewed program director reported that they have not had any circumstances where the facility has been unable to meet the requirements of the staffing plan. In the instances of inclement weather, the program provides additional pay to staff who are held over.

115.313 (c). According to the PAQ, the WOW program exceeds staffing ratios by maintaining the staffing ratios of minimum 1:4 during resident waking hours and 1:8 during resident sleeping hours. As reported

the program has not deviated from the staff ratios of 1:4 during waking hours and 1:8 during resident sleeping hours. The facility is obligated by the Alabama Division of Youth Services to maintain the minimum 1:4 during resident waking hours and 1:8 during resident sleeping hours. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), further states the DYS requirements.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.313 (d). According the WOW program Staffing Plan (dated 1/22/2020), there have been changes to the staffing numbers within the last 12 months. It further stated that the staffing numbers were changed in efforts to improve stability during weekend shifts. The WOW program converted three part-time and one full-time position into three full-time positions. The staffing plan further indicated that the program maintained the same staff/youth ratios, however the position changes were implemented to decrease turnover. In review of shift rosters, the WOW program exceeded the requirements of the standard.

115.313 (e). As reported in the PAQ, the WOW program has a policy and practice in place where intermediate or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment. The two intermediate or higher-level staff interviewed reported that unannounced rounds are conducted by randomly walking through the facility. The rounds occur at least twice per month. They will also review the logbook and video monitoring system. There is form utilized to document the results of the unannounced rounds.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents
 - a. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - b. Alabama Department of Youth Services Policies (2017) Working on Womanhood (WOW) (Program Procedures)
 - c. Pre-Audit Questionnaire (PAQ)
 - d. Search and Seizure (The Working on Womanhood Program) PPT Training
2. Interviews:
 - a. Random sample of staff - 12
 - b. Random Sample of Residents - 8

Findings (By Provision):

115.315 (a). As reported in the PAQ, the WOW program does not conduct cross-gender strip or cross-gender visual body cavity searches of residents. In the past 12 months there have been zero reported cross-gender strip or cross gender visual body cavity searches of residents. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 13), states that "non-medical WOW staff will not conduct Cross-Gender Strip Searches or Cross-Gender visual body cavity searches (meaning a search of the anal or genital opening) except in Exigent Circumstances". It further states that only female staff will conduct searches of all program residents (pg. 14).

115.315 (b). The WOW program reported in the PAQ that it does not permit cross-gender pat-down searches of female residents, absent exigent circumstances. It was also reported that there were zero pat-down searches of female residents that were conducted by male staff; and zero pat down searches of female residents conducted by male staff that did not involve exigent circumstances.

WOW trained 100% of security-staff on conducting cross-gender pat down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs.

Twelve direct care staff, representing staff from all three shifts and a teacher, were interviewed. One hundred percent of staff interviewed indicated that cross-gender pat searches were not permissible. One hundred percent of the interviewed staff stated that they were trained on conducting cross-gender pat searches and searches of transgender and intersex residents; however, most of the staff stated any searches would be conducted by female staff.

One hundred percent of the residents reported that they have never been or had staff of the opposite gender conduct pat-down searches nor been naked in full view of male staff.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.315 (c). The facility indicated in their response to the PAQ that policy request that all cross-gender strip searches and cross-gender visual body cavity searches are documented. The program reported in the PAQ that there was no cross-gender strip or cross-gender visual body cavity searches conducted at the facility in the last 12 months. If there was a need to conduct one there is a procedure in place; and all instances would be documented.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.315 (d). As indicated in the PAQ, the facility has implemented policies and 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, along with policies and procedures that require staff of the opposite gender to announce their presence when entering a resident housing unit.

Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 14), states that “residents will be allowed 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 room checks”. The policy further requires that male staff will not enter female residents’ living units without being accompanied by female staff. The WOW program does utilize the approach of opposite gender staff making an announcement upon entering the unit. As indicated in the policy, such approach is determinate to the treatment modality and the voice announcement of male staff could trigger unpleasant memories for the residents. Male staff use informal greetings when they enter the housing area such as “good evening”, “hello”, “how is everyone doing”, etc.

The WOW has a procedure in place, requiring the announcement of male staff as they enter the housing units. One hundred percent of staff interviewed stated male direct care staff are never allowed to perform shower, dress, or bathroom duties of youth. Four of the eight residents interviewed stated that male staff do not announce their presence when entering the housing area. All eight of the interviewed residents stated that they are never naked or in full view of male staff when using the toilet, showering, or changing clothes.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.315 (e). Per the PAQ, no searches or physical examination of a transgender or intersex resident for the sole purposes of determining the resident's genital status occurred at the WOW program in the past 12 months. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 15) states that "program staff will not search or physically examine a transgender Resident for the sole purpose of determining the Resident's genital status". It further states that the genital status of a resident will be determined by DYS records and interviews with the resident.

One hundred percent of the interviewed staff stated that they were trained on conducting cross-gender pat searches; however, they are not allowed to conduct searches or physical examination of a transgender or intersex offender for the sole purposes of determining the offender's genital status. No searches occurred at WOW in the past 12 months.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.315 (f). As reported in the PAQ, the WOW program trained 100% of security-staff on conducting cross-gender pat down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs. The facility provided the PowerPoint (PPT) presentation of the agencies cross gender and transgender pat search training. It should also be noted that embedded in the training slides is the PREA Resource Center video titled, *Guidance in Cross-Gender and Transgender Pat Searches*.

A review of a sample of staff training records further supported the WOW program meeting the requirements of the provision.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Alabama Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - b. Alabama Department of Youth Services Policies (2017) Working on Womanhood (WOW) (Program Procedures) (Residential Life, Programming and Services Chapter)
 - d. Pre-Audit Questionnaire (PAQ)
 - e. Interpreter Contracts - 2
 - f. PREA Posters - 2

2. Interviews:

- a. WOW program director
- b. Random sample of staff -12

Findings (By Provision):

115.316 (a). As reported in the PAQ, the WOW program, 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. The Alabama Department of Youth Services Policy 13.8 and 13.8.1, (pg.10) states that PREA information "will be provided 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". The policy further indicates that residents who are deaf or hard of hearing, will be provided access to interpreters.

The program further provided that written material will be modified in various formats for effective communication. Such formats include but are not limited to residents who have intellectual disabilities, limited reading skills, are blind, or low vision. According to the Alabama Department of Youth Services Policies (2017) Working on Womanhood (WOW) (Program Procedures) (Residential Life, Programming and Services Chapter), "where indicated, as determined by the Facility Administrator and facility multidisciplinary team, the Youth handbook is translated into the language spoken by the student in the program. An audio copy of the handbook may also be down loaded onto an MP3 player as needed".

It should be noted that there were no youth at the WOW program during the time of the audit that were identified as disabled and/or limited English proficient.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.316 (b). As reported in the PAQ, the WOW program, the WOW program 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 Alabama Department of Youth Services Policy 13.8 and 13.8.1, (pg.10) states that PREA information "will be provided 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". The policy further indicates that residents who are deaf or hard of hearing, will be provided access to interpreters.

The program further provided that written material will be modified in various formats for effective communication. Such formats include but are not limited to residents who have intellectual disabilities, limited reading skills, are blind, or low vision. According to the Alabama Department of Youth Services Policies (2017) Working on Womanhood (WOW) (Program Procedures) (Residential Life, Programming and Services Chapter), "where indicated, as determined by the Facility Administrator and facility multidisciplinary team, the Youth handbook is translated into the language spoken by the student in the program. An audio copy of the handbook may also be downloaded onto an MP3 player as needed".

The interviewed agency head stated that PREA information will be provided 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 who are deaf or hard of hearing, will be provided access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. In addition, written

materials will be modified in various formats to ensure effective communication with residents who have intellectual disabilities, limited reading skills, are blind, or have low vision.

It should be noted that there were no youth at the WOW program during the time of the audit that were identified as disabled and/or limited English proficient.

The WOW program provided a contract for Spanish speaking and interpreter/translator for hearing impaired interpreter services.

115.316 (c). As reported in the PAQ, the WOW program prohibits the use of resident interpreters, readers, or other types of resident assistance. The Alabama Department of Youth Services Policy 13.8 and 13.8.1, (Policy and Procedures), (pg.10), further states that “the program will not rely on resident interpreters, resident readers, or other types of Resident assistance, except in limited circumstances where an extended delay in obtaining and effective interpreter could compromise a Resident’s safety, the performance of first-responder duties, or the investigation of a Resident’s allegations”.

The WOW program reported in the PAQ that there were no instances in the last 12 months where resident interpreters, readers, or other types of resident assistance was needed. One hundred percent of the random staff interviewed reported that resident interpreters are not allowed; nor have resident interpreters, resident readers, or other types of resident assistants been used in retaliation to allegations of sexual abuse or sexual harassment.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - b. Alabama Department of Youth Services Policies (2017) Working on Womanhood (WOW) (Program Procedures)
 - c. University of Alabama Disclosure of Convictions
 - d. University of Alabama Human Resources Policy Manual, Pre-Employment Background Investigations, (dated 12/2/2012)
 - e. University of Alabama Staff Employment Background Investigation Procedure
 - f. Pre-Employment Questionnaire - 20
 - g. Background Checks - 25
 - h. Contract files - 3
 - i. Five-year background check/promotions - 3
2. Interviews:
 - a. HR administrator

Findings (By Provision):

115.317 (a). As reported in the PAQ, the WOW program 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.
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, of 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.

All of the above areas are asked in the Pre-employment questionnaire; in which the employee must acknowledge and sign. The Alabama DYS, Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 8) further reiterated said practices. A review of 26 staff and 11 volunteer/contract personnel files; demonstrated that the WOW program is compliant with this policy.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.317 (b). As reported in the PAQ, the WOW program, has a policy that 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 the residents. The Alabama DYS, Policy 13.8 and

13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 8) states that "WOW will consider any incidents of sexual misconduct, as defined by PREA, in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents".

When interviewing the HR administrator, it was further reiterated that the WOW program has incorporated the above practices in its hiring of staff at the WOW program.

The final analysis of the evidence indicates the facility does consider 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. The policy provided in the PAQ aligns with the intent of the standard, as well as corroboration by the interviewee. Based on this analysis, the audit finds the facility meets standard.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.317 (c). The program indicated in their responses to the Pre-Audit Questionnaire (PAQ) that the program policies requires that before hiring new employees who may have contact with residents the agency shall: (1) Perform a criminal background records check; and (2) 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.

In reviewing the Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014),, Policy and Administrative Procedure, *Hiring and Promotions*, 04-03-103 (dated 12/01/2002), (pg. 8), states that before the program hires any new employees who may have contact with residents, WOW will :

1. Perform a criminal background records check;
2. Consult any child abuse registry maintained by the State or locality in which the employee would work;
3. Consistent with Federal, State, local law, and UA HR guidelines, make every best effort 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; and
4. Perform a criminal background records check for employees seeking a promotion or shift change and the last background check is greater than one year.

An interview with the Human Resources administrator, indicated that when conducting criminal record background checks, WOW 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 considered for promotions. Such actions are also taken for contractors. All employers and contractors at WOW receive a background and criminal record checks conducted through the University of Alabama.

According to the PAQ, in the last 12 months, the program has hired 10 staff who may have contact with residents, who have had criminal background checks. It should be noted that additional staff were hired after the PAQ was completed, and their file was reviewed during the post-audit onsite phase. A review of a sample of 26 personnel files of staff who were hired in the last 12 months, documented that the WOW

program conducted the above referenced background checks. In total the auditor reviewed 37 files (staff/volunteers/contractors) where background and re-background checks were completed.

The final analysis of the evidence indicates the program requires that before hiring new employees who may have contact with residents, the agency shall: (1) Perform a criminal background records check; (2) Consults any child abuse registry maintained by the State or locality in which the employee would work; and (3) 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. The policy provided in the PAQ aligns with the intent of the standard, as well as corroboration by the interviewee. The facility meets this portion of the provision.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.317 (d). The program indicated in their response to the PAQ that agency policies requires that a criminal background records check is completed before enlisting the services of any contractor who may have contact with residents. Consistent with employee background checks; criminal history background checks, including driver's license checks and fingerprinting, shall be conducted on all volunteers, interns, and persons working in the department on contract who have direct contact with offenders.

The contractors, volunteers, and interns are also required to review and sign a Mandatory Pre-Service PREA Audit Questionnaire document addressing any prior sexual abuse in a residential setting. According to the PAQ, in the past 12 months there were 3 contracts for services where criminal background record checks were conducted on all staff covered in the contract who may have contact with residents. A review of 3 contract files reflects that the WOW program meets the requirements of the standard.

115.317 (e). The program indicated in their responses to the Pre-Audit Questionnaire (PAQ) that the program either conducts criminal background records checks at least every five years of current employees and contractors who may have contact with residents or has in place a system for otherwise capturing such information for current employees.

The WOW program, Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (page. 8), "will conduct criminal background records checks at least every five years on current employees and contractors who may have contact with Residents". All WOW program background checks are completed by the UA HR Department. The interview with the Human Resources administrator further confirmed that the WOW program conducts a state child abuse registry check before hiring new employees or contractors.

115. 317 (f). The WOW program has all newly hired and promoted employees complete a Pre-Employee Questionnaire form. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pages. 8-9), states that "employees who may have contact with WOW residents will be required to respond to questions regarding any previous sexual misconduct:

- i. Such questions will be asked in writing along with the child abuse registry check process.
- ii. All existing employees will be required to respond to the questions upon request by program administration and the PREA coordinator. Additionally, UA HR policy requires current employees

to disclose any criminal convictions within 3 days of the conviction; failure to do so will result in disciplinary action including possible termination.

- iii. Questions will be posed again when staff are considered for promotion.
- iv. UA HR policy and procedure dictates the parameters of the staff evaluation process; as a result, if deemed necessary and to the extent possible, questions may be asked periodically during annual evaluations.

When interviewing the human resources staff during the onsite audit, it was reported that the background checks are conducted on employees and contractors every in accordance with the PREA standards. They conduct, state and federal checks, along with the Alabama Child Abuse and Neglect checks. It was further confirmed that all applicants and employees who have contact with residents are asked about previous misconduct in written applications for hiring or promotions.

There were three promotions in 2019; in which applicable background checks were completed.

115.317 (g). According the to the PAQ, the agencies policy states that material omission regarding misconduct, or the provision of materially false information, shall be grounds for termination. The agencies Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 9); further reiterates the employees who fail to report any sexual misconduct, or provide false information, shall be grounds for termination.

The final analysis of the evidence indicates the facility considers material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination. Both the Pre-Employment Questionnaire and facility policies provide evidence to compliance with the standard. Based upon the evidence and analysis, the auditor finds the facility meets standard 115.317 (g).

115.317 (h). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (page. 9), states that the WOW program is “permitted by UA HR policy, to provide a no rehire recommendation for hire to an institutional employer seeking to hire a former WOW employee that engaged in sexual misconduct while employed at the program”. Additional it states that the WOW program will make every effort contact and verify any history of PREA related investigations. The University of Alabama HR will receive and respond to said requests. There are no known requests for PREA related information.

Interviewed HR administrator confirmed that the program will provide information on employment and can provide detailed information on a former employee(s), substantiated allegation of sexual abuse or sexual harassment, upon receiving a request from an institutional employer.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - b. Vision Secure Technologies (Scope of Work)
2. Interviews:
 - a. Agency head
 - b. WOW program director

Findings (By Provision):

115.318 (a). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), pg. 23), addresses the standard requirements that when designing or acquiring any new facility and in planning and substantial expansion or modification of existing facilities, the agency consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse. The facility indicated in their responses to the Pre-Audit Questionnaire (PAQ) that the program has not made substantial expansions or modifications to the existing facility since the last PREA audit.

Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 23), stipulates that the WOW program will maintain a staffing plan that provides staffing at "staff/Resident ratios of a minimum of 1:4 during Resident waking hours and 1:8 during Resident sleeping hours"; thus exceeding the PREA standards. Interviews with the agency head and the program director, further confirmed that the program is required by state law to maintain the above-mentioned ratio requirements. The agency head also reported that the facility updates and technology enhancements are used to assist with monitoring to aid in a safe and secure facility for youth and staff. All substantial upgrades are considered an enhancement to staff supervision and will provide additional means for gathering documentary evidence for internal and external investigations.

A review of the appropriate documentation and review of relevant policies indicates that the program is compliant and exceeds the requirements of the provision of this standard. No corrective action is warranted.

115.318 (b). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), further states that the program will consider how technology will enhance the ability to protect residents; when installing or updating video monitoring, electronic, or surveillance monitoring systems (pg. 20). The program reported in the PAQ that they have installed or updated its video monitoring system, electronic surveillance system, or other monitoring technology since 8/20/12, or since the last PREA audit.

Without divulging too much information that could compromise the safety of the program, the WOW program contracted with Vision Security Technologies to enhance the current video and electronic monitoring system. Such enhancements included but not limited to the installation of 360-degree multi-sensor cameras. Upon discussion with the agency head and program director, the enhancements were a result of the last PREA audit to address any blind spots. Additionally, the enhanced technology system provided the program with high definition and audio recording. As previously stated by the agency head, all facility updates and technology enhancements are used to assist with monitoring to aid in a safe and secure facility for youth and staff. All substantial upgrades are considered an enhancement to staff supervision and will provide additional means for gathering documentary evidence for internal and external investigations.

The Program Director also reported that there were no significant expansions or modifications to the program since 8/20/12 or since the last PREA audit.

A review of the appropriate documentation and review of relevant policies indicates that the program is compliant with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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 evidentiarily 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 compliance determination:

1. Documents:
 - a. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - b. Pre-Audit Questionnaire
 - c. Alabama Department of Youth Services Policies (2017) Working on Womanhood (WOW), Program Procedures, (1.14 Special Investigation Unit)
 - d. Alabama Department of Youth Services Policies (2017) Working on Womanhood (WOW), Program Procedures, (9.10.1 Preservation of Evidence)
 - e. Revised PREA Administration Investigative Protocol
 - f. Sexual Medical Assessment Form
 - g. WOW Medical Screening Form
 - h. Previous SANE Efforts
 - i. Previous Victim Assistance Efforts
 - j. SANE and Medical Agreements
 - k. Staff Victim Assistance Training -1
 - l. Victim Advocate Refresher Training Form, *Demystifying Forensic Medical Exams* - 1
 - m. Memo-Jurisdiction for Criminal Investigations for PREA Allegations
2. Interviews:
 - a. Random sample of staff -12
 - b. SAFE/SANE Staff - 2
 - c. PREA coordinator
 - d. Qualified agency victim advocate

Findings (By Provision):

115.321 (a). The facility indicated in their responses to the Pre-Audit Questionnaire that the agency/program is responsible for conducting administrative sexual abuse investigations. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 18), identifies the responsible parties for conducting allegations of sexual abuse, sexual harassment, and sexual conduct. The policy further states that "when it appears that allegations of Sexual Abuse and Sexual Harassment are supported by evidence of criminal behavior, the investigator(s) ensures that the

allegations are referred for investigation to law enforcement” (pg. 18). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pgs. 18-19), addresses the uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions (pgs. 10-14). The policy covers in all aspects of the investigation, detailing the initial contact with the victim, the forensic examination process,

During the onsite audit, 12 random staff were asked, “Do you know and understand the agency’s protocol for obtaining usable physical evidence if a resident alleges sexual abuse?” One hundred percent of the interviewed staff were aware of the agency’s protocols. A majority of the staff were able to describe the process and steps required to protect physical evidence; which included securing the area, protecting the physical evidence, not allowing the victim to shower or brush teeth, and immediately seeking medical attention. One hundred percent of the interviewed staff could articulate immediate notification to the supervisor, as the first process to protect any usable evidence. The same staff were asked, “Do you know who is responsible for conducting sexual abuse investigations?” Most of the staff could clearly articulate the internal investigators that conducted PREA interviews by names. The staff had limited knowledge or information if an outside entity could conduct PREA investigations. Additionally, at least one medical staff has completed a forensic medical training, for the purpose of understanding the standards.

There were 12 random staff interviews conducted. All of the random staff interviewed stated that they understand the agencies protocol for obtaining usable physical evidence if a resident alleges sexual abuse. The interviewed staff identified at least three different staff as conducting the sexual abuse investigations. It should be noted that one staff reported that the nurse was responsible for conducting the investigations.

A review of the appropriate documentation and review of relevant policies indicates that the program is compliant with the provisions of this standard. No corrective action is warranted.

115.321(b). The program indicated in their responses to the Pre-Audit Questionnaire that the protocol is developmentally appropriate for youth but was not 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. The protocol is appropriate, and is 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.

A review of the appropriate documentation and review of relevant policies indicates that the program is compliant with the provisions of this standard. No corrective action is warranted.

115.321 (c). The program indicated in their responses to the Pre-Audit Questionnaire that the program offers all residents who experience sexual abuse access to forensic medical examinations at an outside facility and that there is no charge for these examinations. The program responded that residents are offered forensic medical examinations without financial cost to the victim. The program also indicated that in the past 12 months there were zero forensic medical exams conducted, no exams performed by SANE/SAFEs, nor any exams were performed by a qualified medical practitioner.

Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014),

(pg. 21), indicates that ‘the program will offer medical and mental health services as appropriate and at no cost, to all Residents who have been victims of sexual misconduct that occurred in any Resident Facility’. The policy further provides a guideline for onsite nursing treatment, victim access to forensic medical examinations and related sexual assault victim services, and victim advocacy services (pg.21).

The WOW program provided documentation of SANE and medical agreements with The Children’s Hospital of Alabama and DCH Regional Medical Center (DCH). The agreements cover the responsibility of said parties, access to medical and victim related services. Review of investigative files and other supportive documents provided by the facility reflect no forensic medical exams were conducted during this period. In interview with the CHIPS and hospital ER SANE staff further confirmed that there were zero SANE exams or allegations of sexual abuse referred to the SANE staff.

A review of the appropriate documentation and review of relevant policies indicates that the program is compliant with the provisions of this standard. No corrective action is warranted.

115.321 (d). The program indicated in their responses to the Pre-Audit Questionnaire that WOW attempts to make available to the victim, a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the program makes available to provide these services a qualified staff member from a community-based organization, or a qualified program staff member. The program provided documented efforts to secure services from rape crisis centers. Additional agreements were provided that outlined collaborative services with the Children’s Hospital of Alabama and DCH Regional Medical Center (DCH).

The agreement for collaborative services with the Children’s Hospital of Alabama stated they would provide non-emergent sexual assault forensic exams (SANE or specially trained M.D.), case management discharge services, education related to sexual abuse and short-term crisis counseling. Additionally, it states that if the Children’s Hospital of Alabama provides counseling services it will be at no cost to the facility. The interviewed CHIPS SANE staff further confirmed the agreement of services between CHIPS and WOW.

Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 23), indicates that the program will have available to the victim a victim advocate. It further stated that “the program will make available to the victim, victim advocacy services provided by a trained Qualified Facility Staff Member (pg. 22)”. The WOW program provided documentation of one staff member who has been trained on *Understanding the Needs of Sexual Assault Victims: A Seminar for those Working in Correctional Settings*.

The auditor interviewed a WOW staff member who has been trained to serve as the agency victim advocate. The WOW victim advocate staff reported they are trained to serve as a spokesperson and support the resident through the process if needed. The WOW victim advocate is able to speak to the resident or speak on behalf of them if needed. Their role is to allow the resident to feel comfortable and supported through the process.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.321 (e). The program indicated in their responses to the Pre-Audit Questionnaire that they would provide, if requested by the victim, a victim advocate, a qualified agency staff member, or a qualified

community-based organization staff member to accompany and support the victim through the forensic medical examination process and investigatory interviews and to provide emotional support, crisis intervention, information, and referrals. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 23), indicates that the program will have available to the victim, a victim advocate. It further stated that “the program will make available to the victim, victim advocacy services provided by a trained Qualified Facility Staff Member” (pg. 22). The WOW program provided documentation of one staff member who has been trained on *Understanding the Needs of Sexual Assault Victims: A Seminar for those Working in Correctional Settings*.

Interviews with the PREA coordinator further confirmed that the WOW program has a contract with the Children’s Hospital of Alabama to ensure residents are provided access to an organization that can provide victim advocacy services. Additionally, the program has an onsite trained advocate who can assist the victim through the process. At this time the WOW program is seeking additional services with a local SAFE program. It was reported that, assistance was solicited from local providers during the first audit cycle and the last audit cycle; and providers indicated that staffing and funding would not permit their agency to assist WOW with those services. An agreement is currently pending for 2020 with the SAFE center in Tuscaloosa. Advocates would be made available through Tuscaloosa County Sheriff’s Office when needed. As previously stated, the WOW program has a trained staff member to serve as the program victim advocate. The WOW victim advocate is able to speak to the resident or speak on behalf of them if needed. Their role is to allow the resident to feel comfortable and supported through the process.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.321 (f). As indicated in the PAQ the WOW program is responsible for conducting administrative investigations and criminal investigations are conducted by outside law enforcement. Alabama Department of Youth Services Policies (2017) Working on Womanhood (WOW), Program Procedures (1.14 Special Investigation Unit), indicates that “upon receipt of an allegation, WOW and/or YSI staff trained in PREA investigative techniques will begin the investigation of sexual misconduct allegations involving student/student, staff/student, and juvenile/staff within 24 hours of notification” (pg. 5). It also states that WOW PREA investigators will conduct administrative investigations in conjunction with criminal investigations which are conducted by an outside law enforcement agency. A memo was provided, confirming the process for criminal investigations.

115.321 (g). The auditor is not required to audit this section.

115.321 (h). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 23), indicates that the program will have available to the victim, a victim advocate. It further stated that “the program will make available to the victim, victim advocacy services provided by a trained Qualified Facility Staff Member (pg. 22). The WOW program provided documentation of one staff member who has been trained on *Understanding the Needs of Sexual Assault Victims: A Seminar for those Working in Correctional Settings*.

The WOW program has a designated qualified staff member who has been trained as a victim advocate. The WOW program provided proof of victim advocacy training for the designated staff member.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is warranted for this standard.

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 compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. WOW Process for Investigating Sexual Assault Allegation
 - c. WOW PREA Administrative Investigation Protocol
2. Interviews:
 - a. Agency head
 - b. Investigative staff

Findings (By Provision):

115.322 (a). The WOW program reported in the PAQ that the program ensures that administrative and criminal investigations are completed for all allegations of sexual abuse and sexual harassment. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 18), and the Alabama Department of Youth Services Policies (2017) *Working on Womanhood (WOW)*, Program Procedures (1.14 Special Investigation Unit) outlines the protocol for conducting administrative and criminal PREA related investigations.

In the PAQ, the facility reported 22 allegations of sexual abuse and sexual harassment were received during the past 12 months. It was also reported that 11 resulted in administrative investigations and 11 were screened out as non PREA related allegations. Upon review of files, there were 24 identified cases. It appears that the facility did not include the two substantiated cases in the PAQ portion that asks number of administrative investigations.

Allegation	# Received	#Investigated	#Referred for Criminal Investigation
<i>Sexual abuse and sexual harassment allegations</i>	24	11	0

An interview with the Agency Head confirmed that the agency ensures administrative or criminal investigations are completed for all allegations of sexual abuse or sexual harassment. It was also stated that the WOW PREA investigators are responsible for investigating all allegations of sexual abuse (assault), sexual harassment, or any sexual conduct that is alleged following a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions. When it appears that allegations of sexual abuse and sexual harassment are supported by evidence of criminal behavior, the investigator(s) ensures that the allegations re-referred for investigation to law enforcement. All referrals shall be documented.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.322 (b). As reported in the PAQ, the WOW program has a policy that requires allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 18), states that “the PREA investigator (s) is responsible for investigating all allegations of Sexual Abuse (Assault), Sexual Harassment, or any Sexual Conduct that is alleged following a uniform evidence for administrative proceedings and criminal prosecutions”. It further states that if the allegations appear to involve criminal behavior, the allegations will be referred for investigation to outside law enforcement (pg. 18). The WOW program policy regarding the referral of sexual abuse and sexual harassment allegations for criminal investigation is published on the agency website. This auditor visited the website in May of 2020 and confirmed the policy was both public and available. There were no cases of criminal allegations referred for outside law enforcement for investigations.

The WOW PREA coordinator also serves as the PREA investigator. Upon interview, the PREA investigator stated that all sexual misconduct allegations involving potentially criminal behavior are reported to UA HR, Tuscaloosa County Sheriff’s Department, and Alabama Department of Human Resources. The program provided documents that indicated *A Procedural Process for Investigating Sexual Assault Allegations* and a *PREA Administrative Investigative Protocol*.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.322 (c). The Tuscaloosa County Sheriff’s Department is responsible for conducting criminal investigations for the WOW program. The WOW program website further reiterates that “the Tuscaloosa County Sheriff’s Office (TCSO) has jurisdiction to investigate criminal complaints at the WOW program, including sexual assault. It is the policy and procedure of the WOW program that, upon a reasonable suspicion that a PREA-related crime has been committed, WOW will immediately contact TCSO, will cooperate fully in the investigation, and will follow all TCSO directives”.

115.322 (d). The auditor is not required to audit this provision of the standard.

115. 322 (e). The auditor is not required to audit this provision of the standard.

Corrective Action:

No corrective action is recommended for this standard.

TRAINING AND EDUCATION

Standard 115.331: Employee training

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

115.331 (a)

- Does the agency train all employees who may have contact with residents on its zero-tolerance policy for sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on residents' right to be free from sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on the right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on the dynamics of sexual abuse and sexual harassment in juvenile facilities? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on the common reactions of juvenile victims of sexual abuse and sexual harassment? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to avoid inappropriate relationships with residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No
- Does the agency train all employees who may have contact with residents on how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities?
☒ Yes ☐ No

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

115.331 (b)

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

115.331 (c)

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

115.331 (d)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

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

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - c. Prison Rape Elimination Act 2003 Staff Training PPT
 - d. PREA Refresher PPT
 - e. Boundaries PPT
 - f. UA Harassment Course Outline
 - g. UA Staff Child Abuse and Harassment Training
 - h. UA Title IX Training
 - i. PREA Signed Acknowledgement Forms
 - j. PREA Initial and Refresher Sign-In Sheets
 - k. COVID Training Memo, (dated 6/9/2009)
2. Interviews:
 - a. Random sample of staff

Findings (By Provision):

115.331 (a). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), the PREA training will be offered to all new employees “during the pre-service/orientation period, and refreshers offered every 2 years”. The following components are included in the training:

- The Agency’s zero-tolerance policy for sexual abuse and sexual harassment;
- How staff fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;
- Residents right to be free from sexual abuse and sexual harassment;
- The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment;
- The dynamics of sexual abuse and sexual harassment in Resident facilities;
- The common reactions of sexual abuse and sexual harassment victims;
- How to detect and respond to signs of threatened and actual sexual abuse;
- How to avoid inappropriate relationships with Residents;
- How to communicate effectively and professionally with Residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming Residents;
- How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.; and
- Relevant laws regarding the applicable age of consent.

Staff Development and Training curriculums were evaluated by the auditor and contained all items indicated above. Sign in sheets for staff initial and refresher training was reviewed showing compliance with the practice of training staff.

Interviews with all random sample staff confirmed that they received PREA education when employed during new employee training and during annual in-service training. Interviews with staff indicated they are all aware of the zero-tolerance policy, employee and resident rights, signs and symptoms of sexual abuse, reporting and responding. One hundred percent of the direct care staff reported being knowledgeable of the topics they had been trained in. The staff were able to describe the training on zero tolerance, resident and staff rights, dynamics of sexual abuse and sexual harassment, prevention and response protocol as well supportive services available to residents. All staff interviewed indicated they have received training on working with vulnerable populations (LGBTQI, prior history of sexual victimization). Staff reported that they received PREA related training in pre-service and annual in-service.

TIME FRAME	NEW EMPLOYEE/ANNUAL IN SERVICE
2/2019-JUNE 2020	51

***Time frames extended due to COVID-19 and the rescheduling of the original audit.

Through random interview with eight staff and review of 49 training records, the auditor confirmed that WOW program staff had been trained on the above defined components. It should also be noted that WOW program provided a memo addressing two staff who were hired during COVID-19. Due to the restrictions put in place between March and June 2020, the new staff were unable to obtain in person PREA training; however, the newly hired staff reviewed the PREA pamphlet and received on-the-job training. The information contained in the training was reviewed with staff by the manager; however, the formal PREA training will occur later in August. A review of the appropriate documentation, interviews with appropriate staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.331 (b). The program reported in the PAQ that training is tailored to meet the unique needs and attributes and gender of the residents at the WOW program. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 6), reiterates that “the training will be tailored to the unique needs and attributes of the adolescent female residents served by the WOW program”.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the program is in compliance with the provisions of this standard. No corrective action is warranted.

115.331 (c). The PAQ indicated that 47 of the WOW staff currently employed were trained or retrained on the PREA requirements. Two additional staff were hired after the initial audit date, and received training on PREA requirements. The facility also reported in the PAQ that staff receive annual or bi-annual refresher training depending on the youth dynamics and characteristics. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), the PREA training will be offered to all new employees “during the pre-service/orientation period, and refreshers offered every 2 years”. Twelve random staff interviews and confirmation from the PREA coordinator indicated that as part of the annual training staff were provided with a PREA informational brochures to keep.

The WOW program provided evidence that refresher training is provided in between annual/bi-annual PREA trainings. Such trainings that occurred included but were not limited to: *Boundaries, UA Child Abuse and Harassment online trainings, and Search and Seizure: Transgender Searches*.

115.331 (d). The PAQ indicated that the program requires employees who may have contact with residents to document, via signature, that they understand the training they received. Staff signature of acknowledgement was provided on the *Prison Rape Elimination Act of 2003 Staff Training Form*. Staff are also acknowledging that they have received the agency brochure. As part of the signature process the employees acknowledged they understood the material presented and had the opportunity to have any of their questions answered regarding the WOW PREA training. The form is only signed for new hires; staff receiving refresher training will complete a sign in document.

During the pre-on-site, on-site, and post-on-site phase, documentation review of 17 employees indicated acknowledgement of training received. The training records reviewed, provided evidence that the facility consistently conducts annual training with staff, and there was adequate documentation of employee signatures verifying the employee's comprehension of the training.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - c. Volunteer Training Records
 - d. Volunteer Orientation Training (PPT)
 - e. Volunteer Acknowledgement Form - 50
 - f. Contract Acknowledgement Form - 3
2. Interviews:
 - a. Volunteers or contractors who have contact with residents - 3

Findings (By Provision):

115.332 (a). According to the PAQ, all volunteers and contractors who have contact with resident have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse/harassment prevention, detection, and response. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 7), states that "WOW will ensure all volunteers and contractors who have contact with residents have been trained on their responsibilities under the DYS policies and WOW procedures regarding the prevention, detection, and response to sexual misconduct".

Upon review of the *WOW Volunteer Orientation Training* (PPT) and the *WOW Contract Training* (PPT), volunteers and contractors are trained consistent with all direct care level staff. Additionally, volunteers/interns/contractors receive handouts, brochures and material consistent with staff training and informational material. Due to COVID-19 there were a limited amount of volunteers still engaged with the program. The WOW program is a part of the University of Alabama, therefore also retains the services of interns/students. There were limitations with outside individuals partaking in activities at the program; and temporarily restricted volunteer services. However, the auditor was able to conduct a telephone interview with one volunteer. The interviewed person reported that they have been volunteering since 2003. They reportedly first received PREA training in 2012 and has been receiving annual training since that date.

It should also be noted that due to COVID-19 there were no contractors providing services for the WOW program.

115.332 (b). It was reported in the PAQ that 16 active and 11 inactive volunteers or contractors who have contact with residents, have been trained on the agencies policies and procedures regarding sexual abuse/harassment prevention, detection, and response. Each volunteer, intern, or contractor is provided a copy of the same brochure staff receive related to sexual abuse detection, prevention, and reporting. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pgs. 7-8), states that the training will be provided based on the level of contact the volunteer/contractor has with the residents. As of the dates of the audit there were 23 total volunteers that were trained and 11 are still active.

One interviewed contractor and two interviewed volunteers supported receiving training in their responsibility regarding sexual abuse and sexual harassment prevention, detection, and response, per agency policy and procedure. The training consists of handouts and a PPT presentation. Some of the areas of discussion are terminology, gender information, looking for signs or anything that looks unusual or how to report.

115.332 (c). As reported in the PAQ, the WOW program maintains documentation confirming that volunteers/contractors understand the training they have received. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 8), requires that the WOW program maintain said documentation confirming that volunteers and contractors understand the training they receive.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - c. PREA Orientation PPT
 - d. PREA Posters/Handouts
 - e. Student Handbook
 - f. Signed Residential Education Statements (31)
2. Interviews:
 - a. Intake staff - 2
 - b. Random sample of residents - 8
3. Onsite observation
 - a. PREA Posters

Findings (By Provision):

115.333 (a). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 9) states that during the intake process, "Residents shall receive information explaining the DYS zero tolerance policy regarding Sexual Abuse and Sexual Harassment and how to report incidents or suspicions of Sexual Abuse or Sexual Harassment. At intake, the DYS Pamphlet 115.333 "What You Should Know about Sexual Abuse and Assault" will be reviewed and read to the resident by their assigned therapist". The DYS pamphlet, the WOW program student handbook, along with posters placed throughout the program provided residents with age appropriate PREA education.

Per the PAQ, 26 residents were admitted during the past 12 months and received information at the time of intake of the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or harassment. One hundred percent of the residents were reported to have received information at the time of intake of the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. Additional youth were placed at the program, since the PAQ was completed; therefore, the auditor reviewed 31 resident intake records. Based on the information provided, and the

acknowledgement through signature, the residents received the required information regarding the programs zero tolerance policy on sexual abuse and sexual harassment.

Two interviewed intake staff reported that intake typically occurs on Tuesdays and Thursdays. During the intake process residents are given PREA pamphlets along with a student handbook. The intake staff reported that a PREA orientation PPT is reviewed with each resident of the program. Eight residents were interviewed. All of the residents reported that they recalled receiving information upon intake and orientation regarding sexual abuse and harassment. Each resident stated PREA related information and the programs rules against sexual abuse and harassment is provided the first day at the facility. There were no intakes during the onsite observation, however the auditor did review the student handbook and observed that there were PREA related posters throughout the program.

A review of the appropriate documentation, interviews with residents and review of relevant policies indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.333 (b). As reported in the PAQ, 26 residents that were admitted in the program during the past 12 months, who's length of stay was for 10 days or more, received comprehensive education regarding their right to be free from both sexual abuse/harassment and retaliation, for reporting such incidents, and on agency policies and procedures for responding to such incidents. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pgs. 9-10) states that "within 24 hours of intake, but not later than 3 days after intake, the residents will be provided comprehensive age-appropriate PREA education through the following materials:

1. Student Handbook PREA information
2. What You Should Know About Sexual Abuse and Assault
3. DYS Youth Safety Guide
4. Power Point Presentation PREA Facts Every Resident Should Know

Two interviewed intake staff reported that a PREA orientation PPT, handbook and pamphlet is reviewed with each resident of the program within 24 hours of placement at the program. Eight residents were interviewed, one hundred percent of them stated PREA related information and the programs rules against sexual abuse and harassment is provided the first day at the facility.

Intake records of 31 residents who entered the program during the audit cycle corroborated that residents received the sexual abuse and sexual harassment education at intake. It should be noted that additional residents were reviewed who were placed after the PAQ was completed. A review of the appropriate documentation, interviews with appropriate staff and residents; and review of relevant policies indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.333 (c). As reported in the PAQ, all residents received PREA related education within 10 days of being placed at the program. The program policy requires that residents receive the PREA education within 24 hours but not less than three day after intake. The program policy (pg. 10) also states that "Current residents who have not received such orientation shall be educated within one year of the

effective date of the PREA standards. Additionally, residents transferred from another facility will receive PREA education upon intake and during orientation.

The residents at the WOW program received information about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment at intake. The two interviewed intake staff reported that they ensure that current and transferred residents have been educated on the agency's zero-tolerance policy on sexual abuse or sexual harassment by providing information via a PPT presentation, handouts and brochures. The interviewed intake staff reported that they ensure current residents, as well as those transferred from other facilities have been educated on the agency's zero tolerance policy on sexual abuse and sexual harassment by reviewing the PREA orientation documents with them; and ensuring they sign the acknowledgement form. The eight interviewed residents reported receiving the PREA related education and information on the same day they were placed at the facility.

Documentation provided to the auditor prior to the onsite visit indicated that the information is given in an age appropriate fashion. Thirty-one signed acknowledgement forms were reviewed.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.333 (d). As indicated in the PAQ, resident PREA education is available in formats accessible to all residents, including those that are: limited English proficient (LEP), deaf, visually impaired, otherwise disabled, limited in their reading skills. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 10), states that "PREA information will be provided 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".

There were no residents who met the criteria of this provision to be interviewed at the time of the audit.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.333 (e). As reported in the PAQ, the agency maintains documentation of offender participation in the PREA education sessions. Documentation of resident's participation in the PREA comprehensive education sessions is available per policy and facility procedures in the resident files. Resident intake records were reviewed to assure fidelity with this documentation. One percent of the files reviewed, indicated that resident education and acknowledgement was properly documented.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.333 (f). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 10), states that "the WOW PREA Coordinator will ensure that PREA information is continuously visible to Residents throughout the facility". This information will be communicated through two or more the following posters:

1. 5 Ways
2. Help Us
3. You Have the Right

4. Protect Yourself & Others
5. Stop Assault
6. Speak

Based on site review, the PREA materials (including posters, resident handbooks, and brochures) were continuously visible in both English and Spanish throughout the facility. The residents housed at the program had ready access to PREA related material. During the site tour PREA related resident education was found to be readily available and accessible.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - c. ACASV Law Enforcement Training
 - d. NIC Curriculum PREA Investigations
 - e. Child Forensic Interviewing Training
 - f. MOSS Group Investigating Sexual Misconduct: Training for Investigators
 - g. Investigator records - 5
2. Interviews:
 - a. Investigative staff - 2

Findings (By Provision):

115.334 (a). As indicated in the PAQ, agency policy requires that investigative staff are trained in conducting sexual abuse investigations in confinement settings. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 6), "In addition to the general

training provided to all employees in paragraph (A) above, WOW will ensure that program investigators responsible for conducting administrative PREA investigations, are trained in conducting such investigations in confinement settings". It should also be noted that the WOW program conducts administrative investigations and criminal investigations are referred to the local law enforcement.

The programs policy further states that "if at any time investigations are conducted by an outside law enforcement agency, the PREA coordinator will at a minimum inform the law enforcement agency of the training requirements under PREA for conducting an investigation within a correctional facility" (pg. 6). The interviewed investigators reported that training included a combination of the initial in person PREA training and online training completed through the National Institute of Corrections (NIC), End Violence Against Women International (EVAWI), and attending conferences when feasible.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.334 (b). As previously stated, WOW program Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg.6) requires investigators to be trained on techniques for interviewing juvenile sexual abuse victims. "WOW will ensure that program investigators responsible for conducting administrative PREA investigations, are trained in conducting such investigations in confinement settings. If at any time investigations are conducted by an outside law enforcement agency, the PREA coordinator will at a minimum inform the law enforcement agency of the training requirements under PREA for conducting an investigation within a correctional facility" (pg. 6). The interviewed investigators reported that the training topics included:

- Techniques for interviewing juvenile sexual abuse victims.
- Proper use of Miranda and Garrity warnings.
- Sexual abuse evidence collection in confinement settings.
- The criteria and evidence required to substantiate a case for administrative or prosecution referral.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.334 (c). As indicated in the PAQ, the agency maintains documentation showing that investigators have completed the required trainings. The PAQ also, indicates that five WOW staff have completed the required training. While conducting the onsite audit, it was reported that the PREA coordinator and the program director serve as back up administrative investigators. All of the administrative investigators are onsite staff. Criminal investigations are conducted by outside law enforcement.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - c. Medical Training Records -12
 - d. Mental Health Training Records - 2
 - e. Prison Rape Elimination Act of 2003, Specialized Mental Health Training
2. Interviews:
 - a. Medical and Mental Health Staff - 5

Findings (By Provision):

115.335 (a). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 7), states that "WOW will ensure that all full-time, part-time, and contingent on-call medical and mental health care practitioners 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 Resident victims of Sexual Abuse and Sexual Harassment; and How, and to whom, to report allegations or suspicions of Sexual Abuse and Sexual Harassment.

As reported in the PAQ, four medical and mental health staff who work regularly at the facility, have received the training required by policy. This represents 100% staff completion. Five staff representing

medical and mental health services were interviewed. All of the interviewed staff were able to provide evidence of training to support their knowledge and understanding to detect signs of sexual abuse, professionally interact with victims, preserve physical evidence, as well as perform health care reporting documentation responsibilities.

The auditor reviewed training records of 12 medical and two mental health staff. The records confirmed the completion of the above-mentioned training.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.335 (b). The WOW program does not conduct forensic medical examinations. Interviews with the medical and mental health staff, further confirmed that they are not trained to conduct such examinations. Forensic medical examinations are contracted for provision at the Children's Hospital of Birmingham (CHIPS); therefore, the facility staff does not receive training in conducting forensic examinations.

As previously stated, the auditor reviewed the training records for 12 medical and two mental health staff; confirming the scope of training received.

A review of the appropriate documentation and review of relevant policies indicates that the program is compliant with the provisions of this standard. No corrective action is warranted.

115.335 (c). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 7), states that "documentation will be maintained verifying that medical and mental health practitioners have received the required specialized training". The program maintains training records of the medical and mental health staff. A sample of medical and mental health staff records were reviewed and confirmed that the staff receives training as required by the standard. As previously stated, the auditor reviewed the training records for 12 medical and two mental health staff; confirming the scope of training received.

A review of the appropriate documentation review of relevant policies indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - c. Aggressive Behavior and Victimization Intake Screening Form - 27
2. Interviews:
 - a. Staff responsible for risk screening - 2
 - b. Random sample of residents - 8
 - c. PREA coordinator

Findings (By Provision):

115.341 (a). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pgs. 10-11), states that "all Residents shall be screened within 24 hours of admission to the WOW program for risk of sexual victimization or sexual abusiveness toward other Residents utilizing the WOW Aggressive Behavior and Victimization Intake Screening Form". The policy further states that the risk level will be reassessed periodically throughout the confinement, "or when warranted due to a referral, request, incident of Sexual Abuse, or receipt of additional information that influences the Resident's risk of Sexual Victimization or abusiveness". According to the PAQ, 100% of the 26 residents who entered the program within the past 12 months were screened for risk of sexual victimization or risk of sexually abusing residents within 72 hours of their entry into the facility. A review of 27 resident files, confirmed that residents are screened within the time frames of this standard. It should be noted that records for residents who entered the facility in between the PAQ and the onsite audit date were also included for review.

Two staff responsible for risk screening were interviewed. Both staff reported that upon admission from another facility a risk of sexual abuse victimization or sexual abusiveness is completed within 24 hours of arrival at the program. The information is ascertained by talking with the youth and assisting them with completing the screening form. They will ask the residents open and close ended questions. Reassessments occur throughout the residents stay at the program. It will occur in the beginning, middle and toward the end (discharge). There is no set timeframe for the reassessment, unless there is a need or change in programming circumstance.

Eight interviewed residents were placed at the program within the last 12 months. All of the interviewed residents recalled being asked questions regarding prior history of sexual abuse, or whether they identified as being gay, lesbian, or bisexual. These questions were asked upon arrival and during the intake process. Six residents reported that they have been asked similar questions again since their arrival at the facility, these questions are asked as a part of their annual/review screening. It should be noted that five of the residents were placed at the program in the last 90 days from the first date of the onsite audit.

A review of 27 records of residents who entered the program in the last 12 months provided evidence that the appropriate screenings occur within 72 hours. The screening tool is called the *Aggressive Behavior and Victimization Intake Screening Form*; and 100% of the intake screening forms were completed within one day; hence exceeding the standards.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.341 (b). The PAQ indicated that the WOW program utilizes a risk assessment that is an objective screening instrument.

A review of the appropriate documentation and relevant policies indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.341 (c). Two interviewed staff responsible for risks screening reported that initial screening takes the following into consideration:

- Age
- Sexual orientation
- Whether they identify as lesbian, gay, bisexual, transgender, or intersex
- Disabilities
- Self-harm behaviors
- Suicide risk
- Intellectuality
- Abuse
- Risk of sexual abuse or abusiveness
- Physical and sexual abuse history

A review of the screening instrument confirmed that the above-mentioned areas are taken into consideration when making programming and housing decisions.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.341 (d). The intake screening tool used by the WOW program takes into consideration, "At a minimum, facilities shall attempt to ascertain information about:

1. Self-harm, suicide risk
2. Victimization and abuse history
3. Risk of sexual victimization or abusiveness
4. Resident self-identification as lesbian, gay, bisexual, or transgender (LGBT is not used as an indicator for potentially sexually abusive behavior)
5. Emotional and cognitive development
6. Mental illness or disabilities
7. Physical ability and possible disabilities
8. Intellectual ability
9. Physical size and stature

10. Age
11. Current charges and offense history
12. Residents will not receive disciplinary action for refusing to disclose any or all information related to her physical and mental ability, sexual orientation, or any information used to assess vulnerability.

The two interviewed staff responsible for risk screening, reported that they attain the information through conversation.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.341 (e). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 11), states that “appropriate protocols are in place to ensure that sensitive resident information is not exploited by staff or other students. Resident risk level and limited information regarding their victimization history is shared with care staff to inform monitoring requirement, room assignment, and influence trauma informed care”.

The designated PREA coordinator, reported that the program uses HIPAA guidelines and policy and procedure require confidentiality of sensitive youth information. Generally, only WOW administration and YSI personnel responsible for Medicaid filings are permitted to access this information. Sharing sensitive information is on a need to know basis for safety and security of youth.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - c. Department of Youth Services Policies (2017), WOW program Procedures
 - d. Intake and Housing assignments
 - e. WOW Health Screening Form
2. Interviews:
 - a. PREA coordinator
 - b. Staff responsible for risk screening -1
 - c. WOW program director
 - d. Medical and mental health staff - 5
 - e. Transgendered/intersex/gay/lesbian/bisexual residents - 3
 - f. Randomly selected staff
3. Onsite Tour
 - a. Review of housing units

Findings (By Provision):

115.342 (a). As stated in the PAQ, the WOW program, uses information from the risk screening to inform housing, bed, work, education, and program assignment with the goal of keeping the resident safe and free from sexual abuse. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 12), states that "WOW will use all information obtained from the intake screening and subsequent testing and interviews, to make housing, bed, program, education, and work assignments for Residents with the goal of keeping all Residents safe and free from Sexual Abuse.

The general characteristics of the population informs the room assignment process and subsequent progression through the program”.

The interviewed PREA coordinator indicated that the program uses information from risk screening during intake (per 115.341) to keep residents safe and free from sexual abuse by using the information to determine supervision and treatment planning needs. Due to the size of the facility, all youth are housed on the secure pod, with their first 24 hours being monitored closely in the safe room. Based on intake screening information and youth dynamics, room assignments will be made or adjusted. During the onsite tour, the auditor was able to observe that residents are placed in single rooms.

The two interviewed staff responsible for risk screening reported that the program uses information from the risk screening during intake to keep residents safe and free from sexual abuse and sexual harassment by determining room assignments, treatment and service planning along with clinical follow up.

115.342 (b). As stated in the PAQ, the WOW program, has a policy that indicates that the residents at risk of sexual victimization will only be placed in isolation if less restrictive measures are inadequate to keeping them and other residents safe. The program further reported that if placed in isolation the resident will have access to legally required educational programming, special education services, and daily large-muscle exercise. The WOW program reported in the PAQ that zero residents at risk of sexual victimization were placed in isolation in the past 12 months.

Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), pg. 12, states that the WOW program “will not use isolation for residents at risk for sexual victimization. Residents at risk of sexual victimization, or those Residents alleging sexual assault may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other Residents safe”. The policy further states the steps that should be taken if isolation is utilized:

1. Whenever a Resident is held in isolation for protective reasons, documentation regarding concerns for the Resident’s safety as well as the reason why alternative means of separation cannot be arranged shall be placed in the Resident’s file.
2. During any period of isolation, Residents will be allowed access to daily large-muscle exercise and required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible.
3. Documentation of programming activities shall be documented using the program’s isolation activity log. Residents held in isolation because of being at risk of Sexual Victimization, shall be afforded a case review every (30) thirty days to determine whether there is a continuing need for separation from the general population (pgs. 12-13).

The interviewed program director reported that the WOW program has not utilized isolation, as a result of a PREA allegation; however, when isolation is utilized it is typically done until safety and order is restored. The use of isolation usually lasts for a couple of hours and maximum time overnight. The WOW program has a “safe room” to use if needed. The interviewed mental health and medical staff reported that if a resident was placed on isolation the resident will be checked daily and pill call will occur on the unit. The interviewed staff reported that they are unaware of any residents being placed on isolation for sexual abuse or sexual harassment.

It should be noted that there were youth placed in isolation who were at risk of sexual victimization.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.342 (c). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 13) states that “lesbian, gay, bisexual, transgender, or intersex Residents shall not be assigned to particular housing, bed, or other activities solely on the basis of such identification or status, nor will WOW consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive”.

The interviewed PREA coordinator reported that the program does not have special housing unit(s) for lesbian, gay, bisexual, transgender or intersex residents. Three residents interviewed were identified as lesbian, gay, or bisexual. All of the three of the residents reported that they were not put in a housing area only for gay, lesbian, bisexual, transgender, or intersex residents. Review of the intake and housing assignments showed no evidence that rooming decisions were made based on a resident identifying as gay, lesbian, bisexual, transgender, or intersex residents.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.342 (d). The program policy will make assignment decisions for transgender or intersex residents on a case by case. Such decision must be made in consultation with “WOW administration as an identified placement option and will be influenced by factors such as health and safety, and whether the placement would present management or security problems” (pg. 13). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 13), states that “placement and programming assignments for transgender or intersex residents placed in the WOW program will be reassessed at least twice each year to review any threats to safety experienced by the Resident. Documentation of the review will be included in the treatment files of residents, and any concerns may involve consultation with DYS administration”.

The interviewed PREA coordinator stated that housing assignments are not made based on LGBTBI identification, all youth entering the program are housed on the secure pod. Additionally, all youth participate in program activities unless there is a risk of safety or security.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.342 (e). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 13), states that “placement and programming assignments for transgender or intersex residents placed in the WOW program will be reassessed at least twice each year to review any threats to safety experienced by the Resident. Documentation of the review will be included in the treatment files of residents, and any concerns may involve consultation with DYS administration”.

The interviewed PREA coordinator reported that the WOW program incorporates placement decisions based on recommendations from DYS. Program participation and housing decisions are made by the WOW administration and all safety concerns are taken into consideration through the residents stay at the site. The interviewed staff(s) responsible for risk screening stated that safety considerations are

made for transgender or intersex residents would be taken into consideration; however, the program has not had a transgender or intersex resident.

115.342 (f). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 13), states that “a transgender or intersex Resident’s own views with respect to her own safety shall be given serious consideration in determining safety issues”. The interviewed PREA coordinator reported that the WOW staff assesses whether placement would present management and security problems. The program placement decisions are made by WOW administration. Such considerations are taken throughout the residents stay at the program.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.342 (g). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg.13), states that “in keeping with standard program protocol and practice that requires all residents to shower separately from other residents, transgender and intersex Residents will shower separately from other Residents”.

All youth at the WOW program shower separately, therefore said practices would also apply to transgender or intersex residents that are placed at the program. The interviewed staff(s) responsible for risk screening also reported that transgender and intersex residents are given the opportunity to shower separately, consistent with all youth placed at the program.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.342 (h). As reported by the PREA coordinator there were no residents placed in isolation that were at risk for sexual victimization.

115.342 (i). As reported in the PAQ, the WOW program reported that if a resident is at risk of sexual victimization is held in isolation, the program will award each resident a review every 30 days to determine whether there is continuing need for separation from the general population. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 13), states that “residents held in isolation because of being at risk of Sexual Victimization, shall be afforded a case review every (30) thirty days to determine whether there is a continuing need for separation from the general population”.

All random interviewed staff could be responsible for supervising residents in isolation; however non were aware of an instance of residents being placed in isolation that were at risk for sexual victimization.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - c. Student Handbook
 - d. DYS Grievance Form
 - e. WOW Grievance Form
 - f. Student Orientation PPT
 - g. Staff PREA Training
2. Interviews:
 - a. Random sample of staff - 12
 - b. Random sample of residents - 8
 - c. PREA coordinator
 - d. DYS advocate

Findings (By Provision):

115.351 (a). As reported in the PAQ, the WOW program has established procedures allowing multiple internal ways for residents to privately report sexual abuse or sexual harassment. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 14), states that residents "have the option to report the incident to any staff member, including contract providers and volunteers, or to the DYS Sexual Assault Hotline".

In review of the student handbook, there are multiple ways provided for the residents to report sexual abuse or sexual harassment. Additionally, the program provided copies of the DYS and WOW grievance forms. The grievance process is one of many ways in which a resident could report sexual abuse or sexual harassment. During the tour of the facility the auditor observed posters PREA posters throughout the program.

The interviewed random staff reported that the residents can privately reporting by using the hotline number, grievances, tell a staff member they are comfortable with, notify case worker, family, or friends. Such reports can be made verbally or in writing.

All of interviewed residents stated that they had multiple ways to report. Most of the residents reported that the hotline is the primary way to report; along with notifying staff (to include a supervisor and the director), filing a grievance, making a written report, probation officer, social worker, or telling a friend or family member.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.351 (b). As reported in the PAQ, the WOW program provides more than one way from residents to report abuse or harassment to a public or private entity that is not part of the agency. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), addresses multiple entities in which a resident can report. Such described entities include but are not limited to: ADAP, JPO, DHR, parent and legal guardian, legal representative, and DYS sexual assault hotline. The policy further states that “in the event that Residents are adjudicated solely for civil immigration purposes, they shall be provided information on how to contact appropriate consular or Homeland Security officials. Methods and contact information for residents to contact their respective consular official can be found in the US Department of State Consular Notification book and Access Reference Card accessible through program administration or PREA Coordinator” (pg. 15).

In review of the *Student Handbook* and the *Student PREA Orientation PPT*, residents are provided multiple ways in which they can make a report of sexual abuse and sexual harassment. Such ways to report also included to a public or private entity that is not a part of the agency. The DYS victim advocate was interviewed, and she further reiterated the resident’s ability to file a grievance with DYS. The DYS advocate routinely visits the program and reviews grievances filed along with case records, and clinical services.

When interviewing the eight residents at the program, seven of the eight stated that they could make a report to someone who does not work at the program. One youth did not want to answer the question, as she was more focused on who they could tell rather than the ability to make a report. All of the interviewed youth indicated that they could make a report without giving their names. Some of the ways they could make a report to an outside person included but was not limited to telling their DYS worker, probation officer, parents, and DYS advocate.

The PREA coordinator further reiterated that residents are able to report allegations of sexual abuse or sexual harassment to their DYS advocate, DYS hotline, and ADAP. It was also reported that residents

can make an anonymous report using the DYS hotline and the information is shared with the PREA coordinator. Additionally, youth may write an anonymous grievance or letter.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.351 (c). The program reported in the PAQ, that there is a policy mandating staff to accept reports of sexual abuse or sexual harassment made verbally, in writing, anonymously and from third parties. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 15), further reiterates said requirements. Additionally, staff are required to document the reports immediately and within the shift of duty in which the report was made” (pg. 15). The resident handbook describes multiple means for residents to report. Such means include verbally, in writing, anonymously, and from third parties. As previously discussed, the residents were able to describe being able to make reports verbally, in writing, anonymously, and from third parties.

The interviewed random sample of staff reported that the residents can privately reporting by using a resident the hotline number, grievance, security or medical staff, family, or friends. Such reports can be made verbally or in writing. All the interviewed staff reported that if a resident makes a report verbally or in writing, sexual abuse or harassment the allegations are responded to immediately and they would document by the end of the shift. Most of the residents reported that the hotline is the primary way to report; along with notifying staff, making a written report, or telling a friend or family member.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.351 (d). As reported in the PAQ, the program 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. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 15) states that “staff are required to accept and document all reports of Sexual Abuse or Sexual Harassment made verbally, in writing, anonymously, or from third parties using a WOW incident report.

The PREA coordinator reported that the program provides residents with tools to help them 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; by using the WOW and DYS grievance processes, reporting issues to staff, and utilizing the DYS hotline.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.351 (e). The program indicated in their response to the Pre-Audit Questionnaire that the agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), pg. 15), states that “residents, staff, or third parties may report allegations via the DYS Sexual Assault Hotline at 1-855-332-1594. The Hotline may be accessed 24 hours a day.

It was also reported that staff are informed of these procedures through policy and training materials. In review of the staff PREA training, such information is provided to staff. The interviewed random staff reported that the residents can privately reporting by using the hotline number, grievance, security or medical staff, family, or friends. Such reports can be made verbally or in writing. All the interviewed staff reported that if a resident makes a report verbally or in writing; reports would be documented immediately or by the end of the shift.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

Standard 115.352: Exhaustion of administrative remedies

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

115.352 (a)

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

115.352 (b)

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

115.352 (c)

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

115.352 (d)

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

115.352 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA
- Are those third parties also permitted to file such requests on behalf of residents? (If a third party, other than a parent or legal guardian, files such a request on behalf of a resident, the facility may require as a condition of processing the request that the alleged victim agree to have the request filed on his or her behalf, and may also require the alleged victim to personally pursue any subsequent steps in the administrative remedy process.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA
- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA
- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA
- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (f)

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

115.352 (g)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - c. Alabama Department of Youth Services Policies (2017), Working on Womanhood Program Procedures
 - d. Resident Handbook
2. Interviews:
 - a. There were no documented grievances for sexual abuse
 - b. DYS advocate

Findings (By Provision):

115.352 (a). The agency has an administrative process for dealing with resident grievances regarding sexual abuse and is not exempt from this standard. Alabama Department of Youth Services Policies (2017), Working on Womanhood Program Procedures (Youth Grievance Process), provides guidance on how resident grievances are managed.

The auditor interviewed the DYS advocate. The DYS advocate reviews all DYS grievances for the WOW program. If the grievance is PREA related, it requires an immediate response. PREA grievances are considered priority grievances. The program has 48 hours to respond to priority grievances.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.352 (b). As reported in the PAQ, the WOW program reported that the agency does not require a resident to use an informal grievance process, or otherwise to attempt to resolve with staff, an alleged incident of sexual abuse. Alabama Department of Youth Services Policies (2017), Working on Womanhood Program Procedures (Youth Grievance Process), (pg. 14), states that "a student may choose to resolve the situation by seeking an informal resolution which may include discussion during a community meeting, consultation with assigned therapist, or through mediation with the support of an administrator. This step is not a requirement and the student may choose to file a grievance in an effort to resolve the situation without attempting an informal resolution". Additionally, the above-mentioned policy states that there is no time limit for residents to file a grievance regarding allegations of sexual abuse. The Resident Handbook provides further guidance to the residents on their ability to file grievances for allegations of sexual abuse and sexual harassment.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.352 (c). Alabama Department of Youth Services Policies (2017), Working on Womanhood Program Procedures (Youth Grievances), (pgs. 18-10) states that "WOW administration will ensure that students

who allege sexual abuse or harassment may submit a grievance without submitting it to the staff member who is the subject of the complaint, and such grievance is not referred to the staff member who is the subject of the complaint nor discussed with another student who may be the subject of the complaint”.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.352 (d). The program reported in the PAQ that there were zero instances in which grievances were filed for alleged sexual abuse. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg.9), states that “a final decision on the merits of any portion of a Grievance alleging sexual abuse comes within 90 days of the initial filing of the Grievance”. Upon review of 10 grievances filed over the last 12 months, there were no documented sexual abuse or sexual harassment related grievances. As there were no PREA-related grievances filed during this time frame, therefore no responses necessitated. The DYS advocate further confirmed that the WOW program did not have any PREA related grievances.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.352 (e). Alabama Department of Youth Services Policies (2017) Working on Womanhood (WOW) (Program Procedures/Youth Grievance Process, establishes that “Third parties, including fellow Youth, staff members, family members, attorneys, and outside advocates, are permitted to assist residents in filing Grievances relating to allegations of sexual abuse, and are also permitted to file such request on behalf of Youth.” (pg. 9). Upon review of the PAQ, it was noted that there were no allegations in the last 12 months where a resident declined third-party assistance in filing a grievance of alleged sexual abuse. The DYS advocate further confirmed that there were no PREA related grievances.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.352 (f). Alabama Department of Youth Services Policies (2017) Working on Womanhood (WOW) (Program Procedures/Youth Grievance Process), establishes procedures for youth to be able to file grievances. The following address the priority grievances:

The Advocacy Representative ascertains if the Grievance is a Priority Grievance.

- a. If a Priority Grievance, the Advocacy Representative immediately notifies the Facility Administrator and all appropriate actions are taken to resolve the issue. Priority Grievances require immediate response to the Youth, not to exceed forty-eight hours.
- b. If the Grievance alleges sexual abuse, if there is cause to believe a criminal act has occurred, or if the Advocacy Representative is uncertain whether a criminal act may have occurred, the Advocacy Representative immediately notifies the Chief Advocate, through the chain of command, who immediately notifies the DYS Special Investigation Unit (SIU). The Chief Advocate and the SIU, in consultation with the Legal Division, then coordinate the investigation, in consultation with General Counsel. The SIU, in consultation with the General Counsel, determines if, and when, to refer an investigation to law enforcement.
- c. For all other Grievances the Advocacy Representative gathers input from the appropriate department head and other witnesses relevant to the Grievance, and reviews the response with the Youth within ten (10) business days of receipt (pg.7).

Per the PAQ, there were zero emergency PREA grievances filed in the past 12 months. A comprehensive review of the grievance documents along with interviews while conducting the site review confirmed application of this standard. In review of 10 grievances filed over the last 12 months, there were no instances documented that were PREA related.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.352 (g). As reported in the PAQ, the WOW program has reported zero number of resident grievances that allege sexual abuse that resulted in disciplinary action by the agency against the resident for having filed the grievances in bad faith. In review of 10 grievances filed over the last 12 months, there were no instances documented that were PREA related. The interviewed DYS advocate reported that she had not received any PREA related grievances.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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

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

115.353 (a)

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

115.353 (b)

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

115.353 (c)

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

115.353 (d)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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 compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - c. WOW Student Handbook
 - d. Documented Efforts for SAFE services
2. Interviews:
 - a. Random sample of residents - 8
 - b. WOW program director
 - c. PREA coordinator

Findings (By Provision):

115.353 (a). The WOW program provides residents with access to an outside victim advocate for emotional supportive services related to sexual abuse. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 23), states that “residents may access outside Victim Advocates for emotional support services related to Sexual Abuse. This access will be available through the contract SANE provider or toll-free hotline numbers”. The policy further states that residents can access a binder of local, state, or national resources, including contact information, it is available in the program school library (pg. 23).

Seven out of eight residents reported that they were aware of services available outside of the facility for dealing with sexual abuse, if ever needed. Of the seven, only two could articulate what services were available outside of the facility if needed. The residents stated that there were services available, however, they never had to use the services. After probing, the residents reported being aware based on their personal experiences prior to being detained and seeing information posted in the living units and in the handbook.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.353 (b). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 23), indicates that “prior to giving them access, the program therapist will inform Residents of the extent to which such communications will be monitored and the extent to which reports of abuse will be forwarded to the appropriate agencies and/or authorities in accordance with mandatory reporting law”.

When residents were asked “do you think the conversations with people from these services would be told to or listened to by someone else?”; one of the residents thought that someone would listen or be told and one didn’t know. There were no identified residents who reported sexual abuse at the WOW program during the audit period.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.353 (c). The WOW program provided correspondence regarding its attempts to enter into a contract with a service provider for emotional support in the event of a sexual abuse or sexual harassment incident. The WOW program has a cooperative agreement with the Children’s Hospital of Birmingham (CHIPS) for the delivery of forensic medical, case management and follow up referral services.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.353 (d). As reported in the PAQ, the program provides residents with reasonable and confidential access to their attorneys or other legal representation; and parents or legal guardians. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 23), states that WOW “will provide residents with reasonable and confidential access to their parents/legal guardians, JPOs, ADAP, and attorneys or other legal representation”.

The interviewed PREA coordinator reported that residents may request to call or write their attorneys at any time. The therapist facilitates this communication. There are no instances where youth would not

have access to their attorneys and legal representation and those meetings would take place in a therapist's office to ensure confidentiality. Additionally, youth have access to their parents/legal guardians through bi-monthly visitation, letter writing, and scheduled video/phone calls. If there is a no contact order through DHR, then youth will not be permitted to contact their parent/legal guardian.

All of the interviewed residents reported receiving mailing addresses and telephone numbers for outside services. The various ways that they received the information included: handouts, counseling sessions, posters, and handbook. Several residents were able to articulate what the information contained; for example, there was information on victim advocates, and where they could get help if needed. Six of the interviewed residents reported that they could talk to the above-mentioned services at any time.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:

- a. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)

Findings (By Provision):

115.354 (a). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 15), states that “a third party reporting form to report allegations of sexual misconduct is available on the Youth Services Institute (YSI) webpage, which is accessible through the UA School of Social Work website”. The policy further indicates that such reports will be submitted to program investigators and PREA coordinator for investigation.

A review of the appropriate documentation and relevant policies indicates that the program is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
2. Interviews:
 - a. Random sample of staff - 12
 - b. Medical and mental health staff - 5
 - c. WOW program director
 - d. PREA Coordinator

Findings (By Provision):

115.361 (a). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (p. 16), requires that an employee "immediately report to their immediate supervisor, any knowledge, suspicion, or information they receive regarding an allegation of Sexual Abuse, Sexual Harassment, or retaliation. Reports should also include any knowledge of neglect or violation of responsibilities that may have contributed to the alleged incident". It is also the responsibility of the

supervisor to simultaneously notify the WOW Care Manager who will notify the PREA coordinator, PREA investigators, and Program Director simultaneously. One volunteer and 12 random staff interviews, indicated a clear understanding of the duty to report the above mentioned immediately.

All random sample of staff interviewed indicated the facility does require 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. The various ways staff indicated that they could make a report included but was not limited to:

- Report to supervisor
- Complete an incident report
- Separate victims
- Follow chain of command
- Call the DYS hotline
- Anonymous letter
- Notify the PREA coordinator

115.361 (b). As reported in the PAQ, the WOW program requires that all staff comply with any applicable mandatory child abuse reporting laws. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 16), states that “all critical incidents should be reported using DYS Form 9.9 Critical Incident Report as outlined in DYS Policy 9.9; and if suspected, reasonably suspicious, or indicated, the child abuse reporting procedure should be followed”.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.361 (c). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 16), states that “apart from reporting to designated supervisors and special investigators, or discussions with law enforcement and designated state agencies as requested, staff are prohibited from revealing any information related to a Sexual Abuse report to anyone other than to the extent necessary, as specified in DYS policy and WOW procedure, to make treatment, investigation, and other security and management decisions”.

Twelve random staff interviewed reported being aware of the agencies procedure for reporting any information related to a resident sexual abuse. Interviewed staff could articulate the necessity to report any incident or alleged incident of sexual abuse or harassment immediately. They are aware of various methods of reporting in writing or verbally to include but not limited to: report to shift supervisor, staff hotline number or medical staff.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.361 (d). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 16), states that “medical and mental health practitioners are required to report Sexual Abuse up their chain of command, as well as where required by mandatory reporting laws.

The interviewed medical and mental health staff all reported that upon admission/intake residents are notified regarding the limitations of confidentiality and the staff duty to report. All of the medical and mental health staff stated that they are required to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment to a designated supervisor or official immediately upon learning of it. Two of the five interviewed medical and mental health staff stated that they have reported

incidents of child abuse to the appropriate parties; and such reports were made by notifying the Department of Human Resources (DHR) and notifying administration. It should be noted that the reports were based on incidents that occurred prior to the resident's arrival at the program.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.361 (e). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 16), states that critical incidents must be immediately reported to the DYS administrative office. Such reports are made by the WOW program director.

The interviewed Program Director and the PREA coordinator reported that if the program receives an allegation of sexual abuse the allegation is reported to the PREA coordinator and the DYS coordinator. If the victim is under the guardianship of the child welfare system, the allegations are reported to the victim's case worker. The parent/legal guardian and the probation officer (PO) are also notified; if applicable. Said reports are made within one business day. The youth at the WOW program are committed to the Alabama DYS. The Alabama DYS service monitor, Guardian Ad Liem, along with the probation; representing the juvenile court jurisdiction will be notified. The PREA coordinator further reiterated that suspected, reasonably suspicious, and indicated sexual abuse allegations will be reported to DHR, law enforcement, designated departments within UA, DYS, youth parent/legal guardian. All notification decisions will be made under the directive of WOW and YSI administration. It should also be noted that reports may be made to the parent/legal guardian and the child welfare system depending on the circumstances of the case. The PREA coordinator also reported that if the victim is under the guardianship of the child welfare system the child welfare system case worker will be immediately notified and no less than 24 hours.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.361 (f). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 17), "all third-party and anonymous reports alleging incidents of sexual misconduct will be reported to the program investigators and PREA Coordinator for investigation".

The interviewed program director reported that all allegations of sexual abuse and sexual harassment are directly reported to the PREA coordinator.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
2. Interviews:
 - a. Agency head
 - b. WOW program director
 - c. Random sample of staff -12

Findings (By Provision):

115.362 (a). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 20), states that "WOW staff and Residents are prohibited from retaliating against other staff or Residents for reporting allegations of Sexual Abuse or Sexual Harassment. Staff and/or Residents who are found to have violated this prohibition shall be subject to disciplinary action". As reported in the PAQ, there were zero instances during the past 12 months where the program determined that a resident was subject to substantial risk of imminent sexual abuse.

The interviewed agency head stated that, the YSI director will collaborate with WOW program administration to establish a plan that will help ensure the safety of the youth. These steps may include, but are not limited to, continuous staff monitoring, separation and additional supervision if the potential perpetrator's identity is known, and frequent status checks with youth regarding any issues or perception of safety. The program director reported that if she becomes aware that a resident is subject to a substantial risk of imminent sexual abuse, they would immediately separate the "students" and staff, assign individuals to separate pods, increase staffing, and notify the PREA coordinator. The agency head and the program director indicated that such actions would occur immediately.

All the interviewed staff could articulate the response process if a resident is at risk of imminent sexual abuse. Most of the staff reported that action is taken immediately to address an resident who is at risk of sexual abuse by immediately notifying the supervisor, separate the victim and perpetrator, and get the victim off the zone and take the victim to medical for follow up services. All of the staff reported that information would only be shared with necessary parties.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
2. Interviews:
 - a. Agency head

b. WOW program director

Findings (By Provision):

115.363 (a). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 17), states that “upon receiving an allegation that a Resident was Sexually Abused while confined at another facility, the WOW program director or PREA coordinator will notify the administrator of the facility where the alleged abuse occurred”. Per the PAQ, there were no allegations of sexual abuse received at WOW which required notification to another facility head. Additionally, there were no reported allegations of sexual abuse received at another facility who which notification was received at WOW during the reporting period.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.363 (b). The WOW program policy requires that the facility head provides such notification as soon as possible, but no later than 72 hours after receiving the allegation. Per the PAQ, there were no allegations of sexual abuse received at WOW which required notification to another facility head. Additionally, there were no reported allegations of sexual abuse received at another facility from which notification was received at WOW during the reporting period. The director reported if they received an allegation from another facility or agency that an incident of sexual abuse or sexual harassment occurred at WOW, she would start an investigation and send the facility investigator to that site to conduct the interviews.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.363 (c). Per the PAQ, there were no allegations of sexual abuse received at WOW which required notification to another facility head. Additionally, there were no reported allegations of sexual abuse received at another facility from which notification was received at WOW during the reporting period.

Based upon review of documentation the facility met the requirements of the provision.

115.363(d). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 17) indicates that “the facility administrator that receives such notification shall ensure that the allegation is investigated in accordance with PREA standards”. Based upon interviews with the director, any allegations consistent with the standard, would be investigated. The director could not recall any recent incidents of allegations within the last 12 months from other facilities. The policy further states that the WOW program director or PREA coordinator “will make every effort to ensure that notification regarding the outcome of the investigation is received from the facility” (pg.17).

The interviewed agency head reported that the Youth Services Institute only operates one residential program, the WOW program. The WOW program director or PREA coordinator will receive allegations from outside entities, other agencies, or programs. Upon receipt of such allegations, the program’s investigative protocol will be followed. The PREA coordinator coordinates the investigation process with the investigators and WOW administration. Any allegations with suspected criminal behavior will be referred to the designated local law enforcement agency for investigation. It was also reported that there are no reports from other programs, facilities or agencies of allegations being reported from another facility or agency.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
2. Interviews:
 - a. Security and non-security staff first responders -12
 - b. Random sample of staff -12

Findings (By Provision):

115.364 (a). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pgs. 17-18), provides guidance on the agencies first responder plan. The policy states that “upon learning of an allegation that a Resident was sexually abused, the first 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 is reported within 72 hours and still allows for the collection of physical evidence, ensure that the alleged victim and 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;
4. The staff First Responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify his/her supervisor;
5. Staff will follow the WOW Administrative Investigative Protocol form; and
6. Seek consultation from their immediate supervision when needed.

Per the PAQ, there were zero allegations of sexual abuse reported in the last 12 months. Interviews were conducted with 12 security staff who may be considered first responders. All the interviewed staff consistently reported that the duties of a first responder to include but are not limited to: take immediate action, stay with the resident, separate the victim from the perpetrator, isolate/secure the scene and secure evidence, call for additional staff, and notify supervisor. Most of the security staff also reported that they would send the victim to medical for an initial evaluation of his/her medical condition.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.364 (b). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 18), states that “If a contract provider or volunteer is the first staff to receive an allegation they would determine when the incident allegedly occurred, request that the resident not take any action that may destroy physical evidence, and notify the program Care Manager. When deemed necessary, the Care Manager may be notified immediately prior to implementation of the initial step”.

It should be noted that all of the staff at WOW are considered first responders. Twelve random staff interviewed consistently reported that the duties of a first responder to include but not limited to: take immediate action, stay with the resident, separate the victim from the perpetrator, isolate/secure the scene and secure evidence, call for additional staff, and notify supervisor. Most of the security staff also reported that they would send the victim to medical for an initial evaluation of his/her medical condition.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
2. Interviews:
 - a. WOW program director

Findings (By Provision):

115.365 (a). The WOW program has 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 PREA coordinator is responsible for the oversight of the said plan. The plan states that the reporting duties are as follows:

1. Any employee shall immediately report to their immediate supervisor, any knowledge, suspicion, or information they receive regarding an allegation of Sexual Abuse, Sexual Harassment, or retaliation. Reports should also include any knowledge of neglect or violation of responsibilities that may have contributed to the alleged incident.
2. The supervisor will immediately notify the WOW Care Manager who will notify the PREA coordinator, PREA investigators, and Program Director simultaneously.
3. The staff First Responder will initiate necessary actions, and document the incident using the WOW incident report form. An administrative investigation will be conducted.
4. All critical incidents should be reported using DYS Form 9.9 Critical Incident Report as outlined in DYS Policy 9.9; and if suspected, reasonably suspicious, or indicated, the child abuse reporting procedure should be followed (pg.16).

When interviewing the program director, the process was further confirmed in that in response to an allegation of sexual abuse; staff are supposed to immediately notify the supervisor, separate the individuals, don't allow the residents to shower, immediately investigate, seek follow up medical care immediately, request follow up with medical and mental health.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
2. Interviews:
 - a. Agency head

Findings (By Provision):

115.366 (a). The WOW program does not have collective bargaining. This section is not applicable. The facility, thereby, materially meets the provision for this standard. The interviewed agency head reported that the WOW program is a part of the University of Alabama and is not unionized nor included in an employee association.

115.366 (b). The auditor was not required to audit this provision.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
2. Interviews:
 - a. Agency head
 - b. Program director
 - c. Designated staff member charged with monitoring retaliation

Findings (By Provision):

115.367 (a). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 20), establishes protective measures for 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 and staff. "The WOW Care Manager or designee is charged with monitoring retaliation for all sexual misconduct allegations and incidents. Measures such as room 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 that fear retaliation for reporting Sexual Abuse or Sexual Harassment or for cooperating with investigations will be implemented in instances of retaliation" (pg. 20).

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.367 (b). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 20), states that “protections from retaliation will be afforded all Residents and staff who report Sexual Abuse or Sexual Harassment and who cooperate with Sexual Abuse or Sexual Harassment investigations. The WOW Care Manager or designee is charged with monitoring retaliation for all sexual misconduct allegations and incidents. Measures such as room 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 that fear retaliation for reporting Sexual Abuse or Sexual Harassment or for cooperating with investigations will be implemented in instances of retaliation.”

The program reported in the PAQ, that no residents were placed on segregated housing after reporting sexual abuse or sexual harassment. The interviewed agency head reported that the program has a staff retaliation monitor that assess for signs of possible retaliation between youth and staff and youth. The interviewed program director reported that the following steps are taken to protect residents from staff retaliation: retaliation monitoring, ongoing training and monthly staff meetings, and supervisory meetings to address any concerns.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.367 (c). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pgs. 20-21), states that “the WOW program, program care manager or designee, will monitor the conduct and treatment of residents and staff for at least 90 days following a report of sexual abuse. The policy further states that the program will monitor to determine “if there are changes that may suggest possible retaliation by residents or staff, and shall act promptly to remedy any such retaliation; monitoring and any concerns shall be discussed with the PREA Response Team” (pg.21).

As reported in the PAQ, there were zero instances where the program had to monitor for retaliation.

The director and the designated staff who monitor for retaliation stated that, if any other individual who cooperates with an investigation expresses a fear of retaliation, the PREA Response Team will make recommendations and ensure program administration takes appropriate measures to protect that individual against retaliation.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.367 (d). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 20) states that “for at least 90 days following a report of Sexual Abuse, the program Care Manager or designee will monitor the conduct or treatment of residents or staff who reported the sexual Abuse and 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, and shall act promptly to remedy any such retaliation. Monitoring and any concerns shall be discussed with the PREA Response Team.”

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.367 (e). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 21) states that “if any other individual who cooperates with an investigation expresses a fear of retaliation, the PREA Response Team will make recommendations and ensure program administration takes appropriate measures to protect that individual against retaliation.”

The interviewed agency head reported that the program retaliation monitor, in concert with the program administrator, will monitor the parties involved. Separation and assignment adjustments will be made when deemed necessary and it does not punish or negatively impact the cooperation of individuals.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.367 (f). The auditor is not required to audit this provision.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - c. Investigations - 26

2. Interviews:

- a. WOW program director
- b. Staff who supervise residents in isolation
- c. Medical and mental health staff

Findings (By Provision):

115.368 (a). As reported in standard 115.343, Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 12), states that “WOW will not use isolation for residents at risk for sexual victimization. Residents at risk of sexual victimization, or those Residents alleging sexual assault may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other Residents safe. This step should be used only until an alternative means of keeping all Residents safe can be arranged”. The policy provides the below guidelines:

- Whenever a Resident is held in isolation for protective reasons, documentation regarding concerns for the Resident’s safety as well as the reason why alternative means of separation cannot be arranged shall be placed in the Resident’s file.
- During any period of isolation, Residents will be allowed access to daily large-muscle exercise and required educational programming or special education services. Residents in isolation shall receive daily visits from a

As reported in the PAQ, no residents at risk for sexual abuse or sexual harassment who were held/placed in involuntary segregation. When reviewing 26 sexual abuse/sexual harassment investigations, there was no indication that an offender was placed in segregated housing to protect an offender who suffered sexual abuse.

Interviews with the program director indicated that there were no residents who were placed on isolation for protection, as a result of sexual abuse allegations. The director also confirmed that a resident would only be placed on isolation from others as a last resort when less restrictive measures are inadequate to keep them safe. While the use of isolation has not be utilized for sexual abuse or sexual harassment allegations; residents who are placed in isolation have done so only until safety and order is restored. This usually lasts a couple of hours and maximum overnight. The program has a safe room if needed. The interviewed mental health and medical staff reported that if a resident was placed on isolation the resident will be checked daily and pill call will occur on the unit. The interviewed staff reported that they are unaware of any residents being placed on isolation for sexual abuse or sexual harassment.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - c. Investigation Reports - 11
2. Interviews:
 - a. Investigative staff - 2
 - b. WOW program director
 - c. PREA coordinator

Findings (By Provision):

115.371 (a). As reported in the PAQ, the program has a policy related to criminal and administrative investigations. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg.18), states that "the PREA investigator(s) is responsible for investigating all allegations of Sexual Abuse (Assault), Sexual Harassment, or any Sexual Conduct that is alleged following a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions".

The two interviewed investigators reported that allegations of sexual abuse and sexual harassment are initiated immediately upon notification. A preliminary investigation often takes place within 24 to 48 hours of receipt of the allegation. The information gathered during the preliminary investigation informs the decision to proceed with a full investigation. Additionally, they will notify behavior health services to follow up with the resident. Anonymous or third-party reports of sexual abuse or sexual harassment are handled the same as any other investigation.

It should be noted that there were 24 PREA related allegations. Thirteen were ruled out as upon review they were not PREA related. The 11 PREA-related allegations that were investigated in the 12-month were reviewed:

Allegation	Number	Finding
Sexual Abuse Staff on Resident	2	Unfounded-not referred for criminal investigations.
Sexual Abuse Resident on Resident	4	Unfounded or Unsubstantiated
Sexual Harassment Staff on Resident	1 (boundaries)	1 Unsubstantiated
Sexual Harassment Resident on Resident	4	3 Unsubstantiated
		1 Unfounded

Total	11	
Referral for Criminal Investigations	0	0

Upon the auditor's review of the 11 PREA investigations conducted at the facility, it was apparent that multiple evidence gathering techniques were used in order to thoroughly investigate each allegation of sexual abuse and/or sexual harassment. Each investigation was completed timely. The results of the facility investigations were also judged by the auditor to have been objective, as the determinations of substantiated, unsubstantiated, and unfounded were made on a case-by-case basis, as independently determined based upon evidence gathered.

115.371 (b). Per the PAQ, the WOW program reported having three specially trained investigators. While conducting the onsite review, it was found that there are five staff are specially trained and responsible for conducting investigations into allegations of sexual abuse and sexual harassment. The specialized investigator training record was provided for three investigators.

During interviews, the two program investigators were able specify specialized training received. The training was described as being a combination of the initial PREA training and online training completed through the National Institute of Corrections (NIC) and End Violence Against Women International (EVAWI). When further probed, both investigators discussed that the training addressing how to conduct both administrative and criminal sexual abuse and sexual harassment investigations, interviewing techniques, crime scene protection, Miranda and Garrity; along with chain of command, and when to request outside support or additional assistance.

115.371 (c). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 18), states that "Investigator(s) assigned to conduct Sexual Abuse and Sexual Harassment investigations shall utilize the skills obtained through receipt of special investigative training".

When interviewing the program investigators, they were able to describe a variety of evidence gathering techniques, and the process by which to proceed toward substantiating an allegation of sexual abuse or sexual harassment. The first steps in initiating an investigation involves the receipt of an incident report. Immediately following receipt of the report, the investigator would review video and audio footage and send the preliminary information to the PREA coordinator. The investigation process includes but is not limited to:

- Allegation received by program administration.
- Information shared with the WOW PREA coordinator
- The WOW PREA coordinator reviews the information to determine if the allegation falls within PREA response.
- If an investigation is needed, a preliminary investigation is conducted and the WOW PREA coordinator forwards the needed information to the designated investigator to begin the investigation.
- If at any point during the investigation criminal behavior or staff custodial misconduct is suspected, the allegation information is also reported to UA HR (when applicable), Tuscaloosa County Sheriff's Department, and the Alabama Department of Human Resources.
- The final report is written by the investigator; along with investigation outcome, and

submitted to the WOW PREA coordinator.

- The WOW PREA coordinator shares the report with the WOW PREA response team for review and comment.
- Investigations are discussed during the monthly PREA response team meetings.
- When applicable, program staff work cooperatively with any outside entities to conduct the investigations.

The evidence gathering process includes but is not limited to: statements (victim/perpetrator/witness), camera footage review; talk to involved parties; and contact outside law enforcement to handle direct evidence. However, the WOW staff will maintain and keep evidence safe until the evidence is turned over to local law enforcement.

115.371 (d). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 18), states that “the program will not terminate an investigation solely because the source of the allegation recants the allegation”.

Interviews with two investigators, reported that they will not terminate an investigation if the source of the allegation recants.

115.371 (e). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 18), states that “When it appears that allegations of Sexual Abuse and Sexual Harassment are supported by evidence of criminal behavior, the investigator(s) ensures that the allegations are referred for investigation to law enforcement”. The two interviewed investigators reported that they do not conduct compelling interviews and guidance is taken from the UA HR on process and procedures for prosecutable crimes. The WOW investigators will conduct the initial interviews but will not continue questioning that appears compelling in nature.

115.371 (f). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 19), states that “the credibility of an alleged victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person’s status as Resident or staff. A Resident who alleges Sexual Abuse will not be required to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation”.

The interviewed investigators reported that the credibility of an alleged victim, suspect, or witness is assessed on an individual basis and not based on a person’s position or status in the program; however prior reports will be reviewed and taken into consideration. It was also reported that under no circumstance would they require a resident who has alleged sexual abuse to submit to a polygraph examination.

115.371 (g). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 19), states that “administrative investigations shall include an effort to determine whether staff action or failures to act contributed to the abuse. All investigations shall be documented in written reports that include a description of the physical and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings. All written documentation/materials and audio files will be collected during the course of an investigation will be stored on a secure thumb drive.”

During interviews with two program investigators it was reported that administrative interviews are documented in written reports. The reports will include any information that was used to make the final determination such as video and audio footage, interviews, pertinent factors that should be considered (such as an individual’s mental or physical state at the time of the interviews). Additionally, every effort is taken to determine what may have contributed to the incident and the information is reviewed and shared with the PREA response team.

115.371 (h). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 19), states that “criminal investigations shall be documented in a written report that contains a thorough description of physical, testimonial, and documentary evidence and attaches copies of all documentary evidence where feasible. Criminal investigations are not conducted by the program or program staff. Criminal investigations will be conducted by the designated law enforcement agency”.

The WOW program investigators do not conduct criminal investigations. Said investigations are referred to the Tuscaloosa County Sheriff's Department.

115.371 (i). Allegations of sexual abuse or sexual harassment that are criminal in nature are referred to local law enforcement. The interviewed investigators reported that the incident would be referred for prosecution when any criminal behavior is suspected. One interviewed investigator reported that a preponderance of evidence will also be taken into consideration.

115.371 (j). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 19), states that “WOW shall retain all written reports for as long as the alleged abuser is incarcerated or employed by the program, plus five years, unless the abuse was committed by a Resident and applicable law requires a shorter period of retention.

115.371 (k). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 19), states that “the departure of the alleged abuser or victim from the employment or commitment to the program shall not provide a basis for terminating an investigation”.

The two interviewed investigators reported that if a staff member alleged to have committed sexual abuse or sexual harassment terminates employment prior to a completed investigation; the investigation will continue and referred to the appropriate entities.

115.371 (l). N/A

115.371 (m). The two interviewed investigators reported that when an outside agency investigates an incident of sexual abuse in the program, the investigators will assist in the process as needed. The interviewed PREA coordinator manager reported that when an outside agency investigates allegations of sexual abuse, WOW and YSI administration cooperates fully with any outside investigations. The PREA coordinator or designee will communicate regularly with the investigating body to stay informed of the progress.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
2. Interviews:
 - a. Investigative staff - 2

Findings (By Provision):

115.372 (a). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 20), defines how to substantiate an allegation of sexual abuse and sexual harassment; and that administrative or criminal investigation findings do not impose a higher standard than preponderance of evidence. The policy further states that "WOW will impose no standard higher than a preponderance of the evidence in determining whether allegations of Sexual Abuse or Sexual Harassment are substantiated" (pg. 20).

Two interviewed investigators stated that a preponderance of evidence is the standard used to substantiate an allegation of sexual abuse or sexual harassment. Both investigators further elaborated that the standard of proof in administrative investigations is, as they state, 51% which constitutes a preponderance of the evidence.

Based on review of 11 investigation files associated with administrative or criminal findings of substantiated cases, it appeared that the WOW program used PREA related standards of preponderance of evidence.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - c. Investigations - 11
 - d. Notification of PREA Investigative Outcome
2. Interviews:
 - a. WOW program director
 - b. Investigative staff - 2

Findings (By Provision):

115.373 (a). As reported in the PAQ, the program 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. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 20), further confirms said policy standard.

The facility reported in the PAQ that there were 11 criminal and/or administrative investigations of alleged resident sexual abuse that were completed by the WOW program. Six of the 11 residents were notified verbally or in writing, of the above results of the investigation. It was further reported that many of the notifications were made verbally. Through corrective action, the WOW program implemented a Notification document so that all notifications are made and documented in a consistent manner.

115.373 (b). The WOW program utilizes an outside entity to conduct the criminal investigations. As reported in the PAQ, there were zero investigations of alleged resident sexual abuse in the facility that were completed by an outside agency in the past 12 months. The program policy also states that "investigators shall request the relevant information from the investigative entity in order to inform the Resident" (pg. 20).

115.373 (c). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 20), states that "following an investigation into a Resident's allegation of Sexual Abuse by a staff member, the investigator/designee shall inform the Resident verbally or in writing as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded. Including whether the staff is no longer assigned within the Resident's living unit; no longer employed in the facility; has been indicted or convicted on a charge of sexual abuse within the facility."

115.373 (d). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg.20), stipulates that following a resident's allegation that he or she has been sexually abused by another resident in an agency facility, the WOW program subsequently informs the victim whenever the:

- Program learns that the alleged abuser has been indicted; and/or
- Convicted on a charge related to Sexual Abuse within the program.

There were no identified residents who reported sexual abuse.

115.373 (e). As reported in the PAQ, the WOW program has a policy that all notifications to residents described under this standard are documented. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 20), confirms said requirements.

115.373 (f). The auditor is not required to audit this provision.

Corrective Action:

The initial review did not have documented instances of all notifications of the outcomes of a PREA related investigation. Upon review and discussion with the WOW program a corrective action was implemented, so that the WOW program will utilize a form to document all notifications of PREA related investigations.

No further corrective action is recommended for this standard.

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

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

115.376 (a)

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

115.376 (b)

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

115.376 (c)

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

115.376 (d)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - c. Investigations - 11
 - d. Email Correspondence (staff inappropriate behaviors)
2. Interviews:
 - a. WOW program director

Findings (By Provision):

115.376 (a). The WOW program reported in the PAQ that staff are subject to disciplinary sanctions up to and including termination for violating agency sexual abuse and sexual harassment policies. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 24), states that "in accordance with UA HR policies, staff shall be subject to disciplinary sanctions up to and including termination for violating Sexual Abuse or Sexual Harassment policies". Interviews with the PREA coordinator and director confirmed understanding of the agency's ability to implement disciplinary sanctions on staff.

115.376 (b). The WOW program reported in the PAQ that there were zero staff that violated the agencies sexual abuse or sexual harassment policies. However, in the event there was an instance of staff violating the sexual abuse and sexual harassment policy, Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 21), states that termination will be presumptive disciplinary sanction for staff who engaged in sexual abuse.

Upon review of the 26 investigations and personnel files, it was found that the zero employees violated the agencies sexual abuse or sexual harassment policies. If there had been any violations, the employees would have been immediately arrested, upon conclusion of the onsite interview, and taken to the local county jail by facility investigators.

115.376 (c). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg,24) requires the employer to consider all factors prior to imposing a disciplinary sanction. This includes the seriousness of the offense, and the employee's work history. According to the PAQ, there was no disciplinary sanctions imposed during the 12-month reporting period that would apply to this standard provision. Upon review of the PREA investigations there was an incident involving staff and boundaries. The incident was investigated and there was not enough evidence to corroborate the allegations, however under the UA's Title IX office and UA Human Resources, a decision was made to remove the staff from the regular schedule and subsequently the staff was discharged from employment.

A review of policy and documentation; found that the facility is in compliance with the provisions of this standard.

115.376 (d). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg,24), indicates that "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, shall be reported to law enforcement agencies and any relevant licensing bodies, unless the activity was clearly not criminal". It was further reported in the PAQ that there were zero instances in which staff from the program were reported to law enforcement or licensing boards.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
2. Interviews:
 - a. Program director

Findings (By Provision):

115.377 (a). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 26), states that “any contractor or volunteer who engages in Sexual Abuse or Sexual Harassment shall be prohibited from contact with Residents, and shall be reported to law enforcement agencies and relevant licensing bodies, unless the activity was clearly not criminal”. As reported in the PAQ, there have been no volunteers or contractors who have been reported to law enforcement agencies and relevant licensing bodies for engaging in sexual abuse of residents in the past 12 months; nor any incidents/persons reported to law enforcement for engaging in sexual abuse of residents.

Based on review of files it is found that the facility meets the requirements of the standard, and

115.377 (b). While there have been no instances in the past 12 months where the WOW program had to take action on a volunteer or contractor. The program has a policy in place to address any volunteers or contractors who violate the PREA standards of sexual abuse and sexual harassment. As stated in Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), “any contractor or volunteer who engages in Sexual Abuse or Sexual Harassment shall be prohibited from contact with Residents, and shall be reported to law enforcement agencies and relevant licensing bodies, unless the activity was clearly not criminal” (pg. 26).

During the interview with the program director, it was reported that the facility would immediately investigate the incident. The volunteer or contractor would be prohibited from coming into and/or providing services at the WOW program.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
2. Interviews:
 - a. WOW program director
 - b. Medical and mental health staff - 5

Findings (By Provision):

115.378 (a). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 25), states that "a Resident may be subject to program disciplinary sanctions by the disciplinary committee only pursuant to a formal disciplinary process following an administrative finding and PREA Response Team recommendation that the Resident engaged in Resident-on-Resident Sexual Abuse or following a criminal finding of guilt for Resident-on-Resident Sexual Abuse". Per the PAQ, there were no administrative or criminal findings of resident-on-resident sexual abuse that occurred at the facility in the last 12 months.

Upon review of incident reports, grievances, and investigations there were no substantiated allegations of resident-on-resident sexual abuse.

115.378 (b). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 25), states that “Any disciplinary sanctions shall be 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. In the event a disciplinary sanction results in isolation the Resident will have access to daily large-muscle exercise and any required educational programming or special education services. Residents in isolation shall receive daily visits from a medical or mental health care clinician. Residents shall also have access to other programs and work opportunities to the extent possible. Documentation will be made using an Isolation Activity Log or similar document.”

115.378 (c). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 25), indicated that “that program disciplinary committee will take into consideration whether a Resident’s mental disabilities or mental illness contributed to her behavior when determining what type of sanction, if any, should be imposed. The disciplinary committee may want to consult with the Resident’s therapist for additional information on the Resident’s mental status before imposing a sanction.”

The interviewed program director reiterated that the WOW program is a therapeutic treatment facility. When assessing sanctions, a resident’s mental disability or mental illness is taken into consideration when making disciplinary sanction decisions.

115.378 (d). Per the PAQ, the WOW program offers therapy, counseling and other interventions designed to address and correct underlying reasons or motivations for the abuse; and the program shall consider whether to require the offending resident to participate in such interventions as a condition of access to programming or other benefits. Interviews with the medical and mental health staff, indicated that all residents are offered individual and group related services. When services are provided, it is voluntary participating, with the expectation that they will participate; however, it is not tied to a reward-based system.

115.378 (e). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 25), states that “the program may discipline a Resident for Sexual Conduct with staff only upon a finding that the staff member did not consent to such conduct”.

115.378 (f). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 25), distinguishes that “for the purpose of disciplinary action, a report of sexual misconduct made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation.”

115.378 (g). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 25), states that “WOW prohibits all sexual activity between Residents and may discipline Residents for such activity. WOW, however, does not deem such activity to constitute Sexual Abuse if it determines that the activity was consensual”.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - c. Medical Screenings - 8
2. Interviews:
 - a. Residents who disclose sexual victimization at risk screening - 7
 - b. Staff responsible for risk screening - 2
 - c. Medical and mental health staff - 5

Findings (By Provision):

115.381 (a). The WOW reported in the PAQ, that 19 of the residents who reported prior victimization during screening were offered a follow-up meeting with a medical or mental health practitioner. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 11), states that "if the screening indicates that a resident has experienced prior Sexual Victimization or has previously perpetrated Sexual Abuse, whether it occurred in an institutional setting or in the community, the assigned therapist will have a follow-up meeting with the resident within 10 days of the intake screening. Consultation with other medical and mental health practitioners will be determined by the Assistant Director and Program Director."

The interviewed staff responsible for risk screening stated that reassessments would occur within 10 days of intake. Seven of the eight interviewed residents disclosed a prior history of sexual victimization at risk screening. When asked whether or not when they told staff at the program that they had been sexually abused; whether they were asked if they wanted to meet with a medical or mental health practitioner; four of the seven youth stated they were asked and met with a counselor.

115.381 (b). As stated previously, residents that have previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community will be offered a follow up meeting with a mental health practitioner within 14 days. The interviewed staff responsible for risk screening reported that if a screening indicates that a resident previously perpetrated sexual abuse a follow up meeting with a mental health practitioner would occur within 10 days.

Youth who reported previous perpetration were provided access to follow up mental health care.

115.381 (c). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 12), states that "any information related to Sexual Abuse, 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, security and management decisions, including housing, bed, education, and program assignments."

115.381 (d). The WOW program policy indicates that “for residents 18 years of age or older, medical and mental health practitioners may obtain informed consent from Residents before reporting information about prior Sexual Victimization that did not occur in an institutional setting” (pg. 12). The interviewed medical and mental health staff reported that informed consent from residents, before reporting prior sexual victimization that did not occur at the program, occurs at intake. Their informed consent is obtained by going over the form with the resident and on occasion from the parents as well (dependent on the custody of the resident).

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - c. Medical Health Screening Form
2. Interviews:
 - a. Medical and mental health staff -5
 - b. Security staff and non-security staff first responders
 - c. Medical and mental health staff first responders

Findings (By Provision):

115.382 (a). As reported in the PAQ, resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. It further stated that the nature and scope of such services are determined by medical and mental health practitioners according to their professional judgement. The WOW program provided a copy of the Medical Health Screening form; however, it should be noted that there were no residents identified that required or requested outside emergency medical treatment or crisis intervention services.

Interviewed mental health and medical staff reported, that victims of sexual abuse receive timely and unimpeded access to emergency medical treatment and crisis intervention services. Such services are rendered immediately upon notification. Medical and mental health staff interviewed during the site review were able to clearly state their responsibilities in responding to a reported incident of sexual abuse.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.382 (b). The WOW program policy states that "the program will offer medical and mental health services as appropriate and at no cost, to all Residents who have been victims of sexual misconduct that occurred in any Resident Facility. Treatment of alleged victims within 72 hours of an incident shall occur as follows:

1. WOW medical staff will ensure that the SANE provider or contract hospital take a medical history in addition to conducting the forensic examination and documenting the extent of any physical injury. Necessary referrals for additional medical services should be documented. Forensic medical examination services shall include:
2. Collection of evidence from the victim, using a kit approved by the appropriate authority;
3. Giving the evidence collected directly to local law enforcement; Tests for sexually transmitted diseases (for example, HIV, Gonorrhea, Hepatitis, and other diseases) and provision of counseling, as appropriate."

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.382 (c). As reported in the PAQ, resident victims of sexual abuse while incarcerated are 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. Interviewed medical and mental health staff reported that such services are addressed through the programs medical team. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 22) states that "Prophylactic treatment and follow-up for sexually transmitted diseases.

1. When the Resident returns to the program WOW nursing staff shall ensure that the Resident victim receives follow-up testing to include, but not be limited to: Gonorrhea, Chlamydia, Syphilis, Hepatitis B, and HIV. Medical follow-up shall reflect retesting five to six months after the initial tests and as determined by the contract physician.
2. The onsite nursing staff shall ensure that the Aggressor, if a Resident, receives testing to include, but not be limited to: Gonorrhea, Chlamydia, Syphilis, Hepatitis B, HPV, and HIV. Medical follow-up shall reflect retesting at six weeks, three months, and six months after the initial tests, and additional testing as determined by the contract physician."

As previously stated, there were no residents at the WOW program who reported sexual abuse while at the program. However, the interviewed medical and mental health staff reported that any needed current or follow up services would be coordinated with the onsite medical staff.

115.382 (d). As reported in the PAQ, the treatment services provided to every victim is without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out the incident.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
2. Interviews:
 - a. Medical and mental health staff - 5

Findings (By Provision):

115.383 (a). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 22) states that “on-site nursing assessment for possible medical issues for sexual assault victims shall occur upon notification of an incident, with referral made to the contract physician for needed treatment and follow-up care”. The policy further indicates that the “program will offer medical and mental health services as appropriate and at no cost, to all Residents who have been victims of sexual misconduct that occurred in any Resident Facility” (pg. 21).

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

185.383 (b). The above referenced policy further states that the evaluation and treatment of victims shall include, as appropriate, follow-up services, treatment plans, and, when clinically indicated, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody (pg. 21). Interviews with medical and mental health staff indicated that the evaluation of and treatment of offenders who have been victimized entail:

- Referral for forensic medical services (local hospital)
 - Conduct follow up services onsite clinical assessment or medical services
 - Mental health will do an initial treatment and service plan
 - If close to release refer to community-based services
 - If necessary, the program can call on an outside group to conduct emotional supportive services
- Additionally, staff will assess the nature of the incident; emotional reactions and how impactful. Services can range from a trauma focused therapeutic modality.

115.383 (c). As reported by the interviewed medical and mental health staff, the treatment and services provided are consistent with the community level of care.

115.383 (d). The interviewed medical staff reported that residents who have been vaginally sexually abused are offered pregnancy tests.

115.383 (e). As reported in the PAQ, if pregnancy results from sexual abuse while incarcerated, WOW will ensure victims receive timely and comprehensive information about, and timely access to, all lawful pregnancy- related medical services. There were no identified allegations in the 12-month reporting period, of sexual abuse or sexual harassment whereas a pregnancy test was necessitated.

115.383 (f). WOW staff will ensure that residents of sexual abuse are provided a sexually transmitted infections test, along with receiving any necessary follow up medical care. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 22) states that “tests for sexually transmitted diseases (for example, HIV, Gonorrhea, Hepatitis, and other diseases) and provision of counseling, as appropriate; and Prophylactic treatment and follow-up for sexually transmitted diseases. When the Resident returns to the program WOW nursing staff shall ensure that the Resident victim receives follow-up testing to include, but not be limited to: Gonorrhea, Chlamydia, Syphilis, Hepatitis B, and HIV. Medical follow-up shall reflect retesting five to six months after the initial tests and as determined by the contract physician.”

There were no identified residents who reported sexual abuse at the WOW program.

115.383 (g). As reported in the PAQ, the WOW program, 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.

There were no substantiated allegations of sexual abuse, based on resident-on-resident reports. As reported by the medical and mental health staff, there were allegations of prior history of sexual abuse, and the facility provides services based on the unique needs of the residents.

115.383 (h). As reported in the PAQ, the WOW program, 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 interviewed mental health staff reported that the evaluation and treatment of residents at WOW is an ongoing process.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - c. PREA Response Team Notes - 9
 - d. PREA Investigation Outcome/Review/Monitoring Form
2. Interviews:
 - a. WOW program director
 - b. PREA coordinator
 - c. Incident review team - 4

Findings (By Provision):

115.386 (a). As reported in the PAQ, the WOW program, conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has

been determined to be unfounded. It was further reported that in the past 12 months, there were 11 criminal and/or administrative investigations of alleged sexual abuse completed at the facility, excluding only unfounded. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 26), states that “the WOW PREA Response Team will conduct an incident review at the conclusion of every sexual misconduct investigation, regardless of investigative outcome. All allegations will be reviewed by the PREA Response Team”.

In the past 12 months there were zero incidents of sexual abuse reviews.

Documentation was provided to indicate that incident reviews of all substantiated and unsubstantiated incidents are reviewed by the PREA Committee as required by the standard. The WOW program reported nine sexual abuse cases that were reviewed by the sexual abuse incident review team.

115.386 (b). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 26) states that “such review shall ordinarily occur within 30 days of the conclusion of the investigation. As reported in the PAQ, there were zero instances of sexual abuse at the facility in the last 12 months. There were nine PREA Response Team reviews reviewed. Based on the set up of the review form, it was difficult to determine the details of what was being reviewed”; however, it should be noted that the reviews occurred consistently within the 30-day time period. Upon corrective action, the WOW program re-implemented the *PREA Investigation Outcome/Review/Monitoring Form*. This form contains all of the areas of review as identified by the standard.

115.386 (c). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 26), states that “the WOW PREA Response Team includes program administration, investigators, clinical staff representative, care staff supervisory representative, medical staff representative, and PREA coordinator.” As reported in the 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 interviewed program director reported that the WOW program has a sexual abuse incident review team. The team is inclusive of upper level management, medical and mental health practitioners.

115.386 (d). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 26), indicated that the review team shall:

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, or intersex identification, status, or perceived status; gang affiliation; or was motivated or otherwise caused by other group dynamics within the program;
3. Discuss 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 levels in that area during different shifts;
5. Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff; and
6. Prepare a report of its findings, including but not necessarily limited to determinations made, any recommendations for improvement, or changes to programming or disciplinary consequences. Recommendations for facility improvements or programmatic changes will be discussed with program administration.
7. Program administration shall work to implement the recommendations for improvement or discuss with the PREA coordinator potential issues and/or reasons the recommendations cannot be implemented. Discussions or communications will be documented.

The interviewed PREA coordinator reported that if the facility conducts a sexual abuse incident review, the team will look to determine if policy or procedural changes are needed. If discrimination was involved based on youth identification or perceived identification, any facility design considerations that may have contributed to the alleged incident, staffing levels or assignments, or technology upgrades. The PREA coordinator will review the information and drafts a statement for the website. There have not been any trends regarding allegations, and it tends to flow based on the population of residents. Some of the actions after the report being submitted, will be to note an overview of the number of allegations from one year to another and post the information on the YSI website.

Five staff who are a part of the incident review team were reported that the review team takes the following into consideration when reviewing incidents of sexual abuse and sexual harassment:

- Whether the allegations are 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 team also examines the areas in the facility where the incident allegedly happened to assess physical barriers; along with staffing levels, and monitoring of technology. One of the team members reported that they previously identified a blind spot in the recreation yard and took action by installing additional cameras. It was also reported that video and monitoring of technology is ongoing; maintained quarterly and suitability is assessed regularly outside of the allegation review process.

In review of the nine PREA Response Team notes, there was no indication that the above-mentioned areas were being assessed. In further discussion with the PREA coordinator, the above areas are discussed however, in order to ensure complete documentation of the process the WOW program will begin utilizing the *PREA Investigation Outcome/Review/Monitoring Form* to ensure complete compliance.

115.386 (e). The above referenced policy further states that “the facility shall implement the recommendations for improvement or document its reasons for not doing so” (pg. 26). As reported in the PAQ, the WOW program, implements the recommendations for improvement of documents its reasons for not doing so. Upon review of the nine completed PREA Response Team reports, there were no identified substantiated cases of sexual abuse. There were no policy or practice changes identified.

Corrective Action:

It is recommended the facility either enhance the PREA Response Team form to include all of the areas that should be taken into consideration; or specify if said areas are addressed by the PREA Response Team. Corrective action was made and the WOW program has implemented the PREA Investigation Outcome/Review/Monitoring Form to ensure that all outcomes of investigation is properly documented. Hence the program has met the requirements of the standard.

No further corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)

Findings (By Provision):

115.387 (a/c). As discussed in the PAQ, the WOW program, reviewed data collected and aggregated under to assess and improve the effectiveness of the facility's sexual abuse prevention, detection, and response policies, practices, and training, including by identifying problem areas, taking corrective action on an ongoing basis. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg.27) states that "the program will collect accurate, uniform data for every allegation of Sexual Abuse and Sexual Harassment within the program. This data will be logged in an internal database updated by the PREA Coordinator or designee."

115.387 (b). Per Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 26), indicates that "data will be aggregated annually". Based upon the auditor's review of available annual reports and per policy, agency data is aggregated annually. The facility is compliant with the intent of the provision.

115.387 (d). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 26), states that "the program shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and incident reviews."

115.387 (e). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 26), states that "as needed, the DYS PREA Coordinator may request incident-based and aggregated data from WOW."

115.387 (f). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 26), indicated that "upon request, the WOW program will provide all program specific data from the previous calendar year to the Department of Justice no later than June 30 of each year on the U.S. Justice Department's Survey of Sexual Violence, Form SSV-5."

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - c. Annual Report
2. Interviews:
 - a. Agency head
 - b. PREA coordinator

Findings (By Provision):

115.388 (a). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 26), states that " the WOW PREA coordinator shall annually review data collected and aggregated in order to assess and improve the effectiveness of the program's Sexual Abuse prevention, detection, and response policies and practices, and training including:

1. Identifying problem areas;
2. Taking corrective action on an ongoing basis; and
3. Preparing an annual report of findings, corrective actions, and improvements."

The interviewed agency head stated that data will be used to identify problem areas and use this information to improve program protocols, policies, training, and facility enhancements. This will be reviewed after discussion of PREA allegations during the monthly team meetings.

The interviewed PREA coordinator reported that the WOW program reviews data collected and aggregated to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training. It was also reported that the number of allegations is assessed regularly during periodic PREA Response Team meetings, and annual data is reviewed by the PREA coordinator annually. This information is used to determine if additional surveillance equipment is needed, if supervision strategies should be adjusted, or if additional training is needed for staff or students. Additionally, the PREA coordinator will review the information and share it the PREA response team and WOW administration when adjustments are needed. An annual summary is provided on the YSI website and a more detailed report is available upon request.

115.388 (b). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 26), states that “the program’s annual PREA report shall include a comparison of the current year’s data and corrective actions with those from prior years and shall provide an assessment of the program’s progress in addressing Sexual Abuse and Sexual Harassment.

115.388 (c). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 26), indicated that “the WOW annual PREA report shall be developed by the PREA Coordinator, reviewed by the PREA Response Team, and approved by the YSI Director. The report will be available to the public through the program’s website.” The interviewed agency head reported that any annual reports and annual information provided on the YSI website is approved by the YSI director.

115.388 (d). When complete the above mentions reports, names and descriptors are not used in the annual summary. The material not included in the annual summary is noted on the program website. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 26), states that “the program may redact specific material from the reports when publication would present a clear and specific threat to the safety and security of the program and its residents. The nature of the material redacted will be noted”.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Pre-Audit Questionnaire (PAQ)
 - b. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014)
 - c. Annual Report
2. Interviews:
 - a. PREA coordinator

Findings (By Provision):

115.389 (a). The WOW program reported in the PAQ that incident-based and aggregate data is securely retained. Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 28), provides direction on the agencies responsibility to collect and retain incident-based and aggregate data securely. Said data is made readily available to the public at least annually through the agency website. The program maintains sexual abuse data collected pursuant to 115.387 for at least 10 years after the date of initial collection.

During interview, the PREA coordinator, it was reported that the PREA coordinator is responsible for reviewing the information and sharing it with the PREA response team. The WOW administration will make adjustments as needed. The database is stored on a secure thumb drive and initials are used instead of names. Action is taken if needed based on data and trends.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.389 (b). The annual numbers are provided on the website however a more detailed report is available upon request. The WOW PREA coordinator provided a copy of the annual report.

115.389 (c). As reported in the PAQ, the WOW program, removes all personal identifiers before making aggregate sexual abuse data public. Upon review of the report there are no personal identifiers indicated.

115.389 (d). Policy 13.8 and 13.8.1, *Prison Rape Elimination Act (PREA) Rules and Regulations*, (dated 04/25/2014), (pg. 28), indicates that sexual abuse data is collected pursuant to 115.387 and maintained for at least ten (10) years.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. DYS Inspection
2. Interviews:
 - a. PREA coordinator

Findings (By Provision):

115.401 (a). The WOW program website contains the results of all of the PREA audits conducted since 2014.

115.401 (b). As reported by the PREA coordinator, the WOW program is the only facility operated by the governing agency.

115.401 (h). During the inspection of the physical plant the auditor and was escorted throughout the program by the director, PREA coordinator, and other management staff, integral to the functioning of the WOW program. The auditor was provided unfettered access throughout the institution. Specifically, the auditor was not barred or deterred entry to any areas. The auditor had the ability to freely observe,

with entry provided to all areas without prohibition. Based on review of documentation the facility is compliant with the intent of the provision.

A review of the appropriate documentation, interviews with staff, and review of relevant policies, indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.401 (i). During the onsite visit, the auditor and her team was provided access to all documents requested. All documents requested were received to include but not limited to employee and resident files, sensitive documents, and investigation reports. Based on review of documentation the facility is compliant with the intent of the provision.

115.401 (m). The audit team was provided private rooms throughout the program to conduct resident interviews. The staff staged the residents in a fashion that the auditor team members did not have to wait between interviews. The rooms provided for resident interviews were soundproof and somewhat visually confidential from other residents which was judged to have provided an environment in which the offenders felt comfortable to openly share PREA-related content during interview. It should also be noted that additional precautionary measures were taken to ensure proper social distancing due to the COVID-19.

A review of the appropriate documentation and interviews with staff indicates that the program is in compliance with the provisions of this standard. No corrective action is warranted.

115.401 (n). Residents were able to submit confidential information via written letters to the auditor PO BOX or during the interviews with the audit team. The audit team members did not receive any correspondence from the residents of the WOW program.

Corrective Action:

No corrective action is recommended for this standard.

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 compliance determination:

1. Documents:
 - a. Agency Website

Findings (By Provision):

115.403 (f). The WOW program, posts its PREA Audit reports on the agency website. The reports are available for review at <https://socialwork.ua.edu/research/youth-services-institute/wow-program/>. There is a link to the Final PREA Audit reports provided on the right section of the page, under forms and reports. The program is compliant with the intent of the provision.

Corrective Action:

No corrective action is recommended for this standard.

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.

Latera M. Davis

8/7/2020

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.