PREA Facility Audit Report: Final

Name of Facility: Southeast Alabama Youth Services Louisville Program
Facility Type: Juvenile
Date Interim Report Submitted: 10/09/2024
Date Final Report Submitted: 01/27/2025

Auditor Certification	
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.	☒
I have not included in the final report any personally identifiable information (PII) about any inmate/resident/detainee or staff member, except where the names of administrative personnel are specifically requested in the report template.	☒
Auditor Full Name as Signed: Latera Davis	**Date of Signature:** 01/27/2025

AUDITOR INFORMATION	
Auditor name:	Davis, Latera
Email:	laterad@yahoo.com
Start Date of On-Site Audit:	08/25/2024
End Date of On-Site Audit:	08/26/2024

FACILITY INFORMATION	
Facility name:	Southeast Alabama Youth Services Louisville Program
Facility physical address:	76 Victoria Street, Louisville, Alabama - 36048
Facility mailing address:	2856 Horace Shepard Drive, Dothan, Alabama - 36303

Primary Contact

Name:	Kaycie Ludlam
Email Address:	kayciel@saysdothan.com
Telephone Number:	334-983-8377

Superintendent/Director/Administrator	
Name:	Tabitha Brannon
Email Address:	tbrannon@saysdothan.com
Telephone Number:	334-983-8377

Facility PREA Compliance Manager	
Name:	Tammy Spiegner
Email Address:	tspeigner@saysdothan.com
Telephone Number:	

Facility Health Service Administrator On-Site	
Name:	Heather Austin
Email Address:	haustin@saysdothan.com
Telephone Number:	334-367-0006

Facility Characteristics	
Designed facility capacity:	16
Current population of facility:	13
Average daily population for the past 12 months:	14
Has the facility been over capacity at any point in the past 12 months?	Yes
What is the facility’s population designation?	Mens/boys

Which population(s) does the facility hold? Select all that apply (Nonbinary describes a person who does not identify exclusively as a boy/man or a girl/woman. Some people also use this term to describe their gender expression. For definitions of "intersex" and "transgender," please see https://www.prearesourcecenter.org/standard/115-5)	
Age range of population:	12-19
Facility security levels/resident custody levels:	Medium Risk
Number of staff currently employed at the facility who may have contact with residents:	24
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	1
Number of volunteers who have contact with residents, currently authorized to enter the facility:	1

AGENCY INFORMATION	
Name of agency:	Southeast Alabama Youth Services
Governing authority or parent agency (if applicable):	
Physical Address:	2850 Horace Shepard Drive , Dothan , Alabama - 36303
Mailing Address:	
Telephone number:	

Agency Chief Executive Officer Information:	
Name:	
Email Address:	

Telephone Number:	

Agency-Wide PREA Coordinator Information

Name:	Kaycie Ludlam	Email Address:	kayciel@saysdothan.com

Facility AUDIT FINDINGS

Summary of Audit Findings

The OAS automatically populates the number and list of Standards exceeded, the number of Standards met, and the number and list of Standards not met.

Auditor Note: In general, no standards should be found to be "Not Applicable" or "NA." A compliance determination must be made for each standard. In rare instances where an auditor determines that a standard is not applicable, the auditor should select "Meets Standard" and include a comprehensive discussion as to why the standard is not applicable to the facility being audited.

Number of standards exceeded:	
0	

Number of standards met:
43

Number of standards not met:	
0	

POST-AUDIT REPORTING INFORMATION

GENERAL AUDIT INFORMATION

On-site Audit Dates

1. Start date of the onsite portion of the audit:	2024-08-25
2. End date of the onsite portion of the audit:	2024-08-26

Outreach

10. Did you attempt to communicate with community-based organization(s) or victim advocates who provide services to this facility and/or who may have insight into relevant conditions in the facility?	(●) Yes ( ) No
a. Identify the community-based organization(s) or victim advocates with whom you communicated:	Alabama Division of Youth Services National Sexual Assault Line Southeast Alabama Child Advocacy Center

AUDITED FACILITY INFORMATION

14. Designated facility capacity:	16
15. Average daily population for the past 12 months:	14
16. Number of inmate/resident/detainee housing units:	1
17. Does the facility ever hold youthful inmates or youthful/juvenile detainees?	( ) Yes ( ) No (●) Not Applicable for the facility type audited (i.e., Community Confinement Facility or Juvenile Facility)

Audited Facility Population Characteristics on Day One of the Onsite Portion of the Audit	
Inmates/Residents/Detainees Population Characteristics on Day One of the Onsite Portion of the Audit	
18. Enter the total number of inmates/ residents/detainees in the facility as of the first day of onsite portion of the audit:	15
19. Enter the total number of inmates/ residents/detainees with a physical disability in the facility as of the first day of the onsite portion of the audit:	0
20. Enter the total number of inmates/ residents/detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) in the facility as of the first day of the onsite portion of the audit:	0
21. Enter the total number of inmates/ residents/detainees who are Blind or have low vision (visually impaired) in the facility as of the first day of the onsite portion of the audit:	0
22. Enter the total number of inmates/ residents/detainees who are Deaf or hard-of-hearing in the facility as of the first day of the onsite portion of the audit:	0
23. Enter the total number of inmates/ residents/detainees who are Limited English Proficient (LEP) in the facility as of the first day of the onsite portion of the audit:	0
24. Enter the total number of inmates/ residents/detainees who identify as lesbian, gay, or bisexual in the facility as of the first day of the onsite portion of the audit:	0

25. Enter the total number of inmates/ residents/detainees who identify as transgender or intersex in the facility as of the first day of the onsite portion of the audit:	0
26. Enter the total number of inmates/ residents/detainees who reported sexual abuse in the facility as of the first day of the onsite portion of the audit:	1
27. Enter the total number of inmates/ residents/detainees who disclosed prior sexual victimization during risk screening in the facility as of the first day of the onsite portion of the audit:	0
28. Enter the total number of inmates/ residents/detainees who were ever placed in segregated housing/isolation for risk of sexual victimization in the facility as of the first day of the onsite portion of the audit:	0
29. Provide any additional comments regarding the population characteristics of inmates/residents/detainees in the facility as of the first day of the onsite portion of the audit (e.g., groups not tracked, issues with identifying certain populations):	On the first day of the onsite portion of the audit, the auditor was provided with a comprehensive list of all residents in the facility. The facility houses all male residents. The facility was able to utilize data from the risk assessment to identity any targeted populations.
Staff, Volunteers, and Contractors Population Characteristics on Day One of the Onsite Portion of the Audit	
30. Enter the total number of STAFF, including both full- and part-time staff, employed by the facility as of the first day of the onsite portion of the audit:	22
31. Enter the total number of VOLUNTEERS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	1

32. Enter the total number of CONTRACTORS assigned to the facility as of the first day of the onsite portion of the audit who have contact with inmates/residents/detainees:	2
33. Provide any additional comments regarding the population characteristics of staff, volunteers, and contractors who were in the facility as of the first day of the onsite portion of the audit:	On the first day of the onsite portion of the audit, the auditor was provided with a comprehensive list of all staff by title and shift.

INTERVIEWS

Inmate/Resident/Detainee Interviews

Random Inmate/Resident/Detainee Interviews

34. Enter the total number of RANDOM INMATES/RESIDENTS/DETAINEES who were interviewed:	9
35. Select which characteristics you considered when you selected RANDOM INMATE/RESIDENT/DETAINEE interviewees: (select all that apply)	☑ Age ☑ Race ☑ Ethnicity (e.g., Hispanic, Non-Hispanic) ☑ Length of time in the facility ☑ Housing assignment ☐ Gender ☐ Other ☐ None

36. How did you ensure your sample of RANDOM INMATE/RESIDENT/DETAINEE interviewees was geographically diverse?	As an auditor, the process of selecting residents for interviews is designed to ensure a fair and unbiased representation of the population. We use a random selection method, often through a random number generator or a similar unbiased tool, to choose residents from the list. This process helps us gather a diverse range of perspectives and ensures that no particular group is either favored or overlooked. Our goal is to obtain an accurate and comprehensive understanding of the environment and conditions from various residents' viewpoints.
37. Were you able to conduct the minimum number of random inmate/ resident/detainee interviews?	● Yes ○ No
38. Provide any additional comments regarding selecting or interviewing random inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	While the facility only has one housing unit, the auditor selected residents who were representative of each open bay housing room. As an auditor, the process of selecting residents for interviews is designed to ensure a fair and unbiased representation of the population. Typically, we use a random selection method, often through a random number generator or a similar unbiased tool, to choose residents from the list.
Targeted Inmate/Resident/Detainee Interviews	
39. Enter the total number of TARGETED INMATES/RESIDENTS/DETAINEES who were interviewed:	1

As stated in the PREA Auditor Handbook, the breakdown of targeted interviews is intended to guide auditors in interviewing the appropriate cross-section of inmates/residents/detainees who are the most vulnerable to sexual abuse and sexual harassment. When completing questions regarding targeted inmate/resident/detainee interviews below, remember that an interview with one inmate/resident/detainee may satisfy multiple targeted interview requirements. These questions are asking about the number of interviews conducted using the targeted inmate/resident/detainee protocols. For example, if an auditor interviews an inmate who has a physical disability, is being held in segregated housing due to risk of sexual victimization, and disclosed prior sexual victimization, that interview would be included in the totals for each of those questions. Therefore, in most cases, the sum of all the following responses to the targeted inmate/resident/detainee interview categories will exceed the total number of targeted inmates/residents/detainees who were interviewed. If a particular targeted population is not applicable in the audited facility, enter "0".	
40. Enter the total number of interviews conducted with inmates/residents/detainees with a physical disability using the "Disabled and Limited English Proficient Inmates" protocol:	0
40. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

40. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	As an auditor, my corroboration strategies to determine if the specific population exists within the audited facility include multiple layers of verification: Information from the PREA Audit Questionnaire (PAQ): I analyze data provided in the PAQ, which includes demographic information, incident reports, and other relevant statistics about the resident population. Onsite Documentation Review: During the onsite visit, I review various documentation, such as intake forms, resident rosters, medical records, incident reports, and any other relevant documents that can provide insight into the demographics and specific populations within the facility. Interviews and Discussions: I conduct interviews and hold discussions with a range of individuals, including staff, inmates/ residents, and detainees. These conversations provide firsthand accounts and personal insights that complement the data collected from the PAQ and documentation. Staff members often have valuable insights about the population's dynamics and any specific needs or issues that might not be captured in written records. Observation: While onsite, I observe the facility's operations, resident interactions, and living conditions. This helps corroborate the information obtained from documents and interviews and provides a more holistic understanding of the facility's environment. By combining these methods, I ensure that the identification and understanding of the population within the facility are accurate and comprehensive. This multi-faceted approach allows me to cross-reference data from various sources, thus increasing the reliability and validity of the findings.

41. Enter the total number of interviews conducted with inmates/residents/ detainees with a cognitive or functional disability (including intellectual disability, psychiatric disability, or speech disability) using the "Disabled and Limited English Proficient Inmates" protocol:	0
41. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

41. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	As an auditor, my corroboration strategies to determine if the specific population exists within the audited facility include multiple layers of verification: Information from the PREA Audit Questionnaire (PAQ): I analyze data provided in the PAQ, which includes demographic information, incident reports, and other relevant statistics about the resident population. Onsite Documentation Review: During the onsite visit, I review various documentation, such as intake forms, resident rosters, medical records, incident reports, and any other relevant documents that can provide insight into the demographics and specific populations within the facility. Interviews and Discussions: I conduct interviews and hold discussions with a range of individuals, including staff, inmates/ residents, and detainees. These conversations provide firsthand accounts and personal insights that complement the data collected from the PAQ and documentation. Staff members often have valuable insights about the population's dynamics and any specific needs or issues that might not be captured in written records. Observation: While onsite, I observe the facility’s operations, resident interactions, and living conditions. This helps corroborate the information obtained from documents and interviews and provides a more holistic understanding of the facility’s environment. By combining these methods, I ensure that the identification and understanding of the population within the facility are accurate and comprehensive. This multi-faceted approach allows me to cross-reference data from various sources, thus increasing the reliability and validity of the findings.

42. Enter the total number of interviews conducted with inmates/residents/ detainees who are Blind or have low vision (i.e., visually impaired) using the "Disabled and Limited English Proficient Inmates" protocol:	0
42. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

42. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	As an auditor, my corroboration strategies to determine if the specific population exists within the audited facility include multiple layers of verification: Information from the PREA Audit Questionnaire (PAQ): I analyze data provided in the PAQ, which includes demographic information, incident reports, and other relevant statistics about the resident population. Onsite Documentation Review: During the onsite visit, I review various documentation, such as intake forms, resident rosters, medical records, incident reports, and any other relevant documents that can provide insight into the demographics and specific populations within the facility. Interviews and Discussions: I conduct interviews and hold discussions with a range of individuals, including staff, inmates/ residents, and detainees. These conversations provide firsthand accounts and personal insights that complement the data collected from the PAQ and documentation. Staff members often have valuable insights about the population's dynamics and any specific needs or issues that might not be captured in written records. Observation: While onsite, I observe the facility's operations, resident interactions, and living conditions. This helps corroborate the information obtained from documents and interviews and provides a more holistic understanding of the facility's environment. By combining these methods, I ensure that the identification and understanding of the population within the facility are accurate and comprehensive. This multi-faceted approach allows me to cross-reference data from various sources, thus increasing the reliability and validity of the findings.
43. Enter the total number of interviews conducted with inmates/residents/ detainees who are Deaf or hard-of-hearing using the "Disabled and Limited English Proficient Inmates" protocol:	0

43. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

43. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	As an auditor, my corroboration strategies to determine if the specific population exists within the audited facility include multiple layers of verification: Information from the PREA Audit Questionnaire (PAQ): I analyze data provided in the PAQ, which includes demographic information, incident reports, and other relevant statistics about the resident population. Onsite Documentation Review: During the onsite visit, I review various documentation, such as intake forms, resident rosters, medical records, incident reports, and any other relevant documents that can provide insight into the demographics and specific populations within the facility. Interviews and Discussions: I conduct interviews and hold discussions with a range of individuals, including staff, inmates/residents, and detainees. These conversations provide firsthand accounts and personal insights that complement the data collected from the PAQ and documentation. Staff members often have valuable insights about the population's dynamics and any specific needs or issues that might not be captured in written records. Observation: While onsite, I observe the facility's operations, resident interactions, and living conditions. This helps corroborate the information obtained from documents and interviews and provides a more holistic understanding of the facility's environment. By combining these methods, I ensure that the identification and understanding of the population within the facility are accurate and comprehensive. This multi-faceted approach allows me to cross-reference data from various sources, thus increasing the reliability and validity of the findings.

44. Enter the total number of interviews conducted with inmates/residents/ detainees who are Limited English Proficient (LEP) using the "Disabled and Limited English Proficient Inmates" protocol:	0
44. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	■ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

44. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	As an auditor, my corroboration strategies to determine if the specific population exists within the audited facility include multiple layers of verification: Information from the PREA Audit Questionnaire (PAQ): I analyze data provided in the PAQ, which includes demographic information, incident reports, and other relevant statistics about the resident population. Onsite Documentation Review: During the onsite visit, I review various documentation, such as intake forms, resident rosters, medical records, incident reports, and any other relevant documents that can provide insight into the demographics and specific populations within the facility. Interviews and Discussions: I conduct interviews and hold discussions with a range of individuals, including staff, inmates/ residents, and detainees. These conversations provide firsthand accounts and personal insights that complement the data collected from the PAQ and documentation. Staff members often have valuable insights about the population's dynamics and any specific needs or issues that might not be captured in written records. Observation: While onsite, I observe the facility’s operations, resident interactions, and living conditions. This helps corroborate the information obtained from documents and interviews and provides a more holistic understanding of the facility’s environment. By combining these methods, I ensure that the identification and understanding of the population within the facility are accurate and comprehensive. This multi-faceted approach allows me to cross-reference data from various sources, thus increasing the reliability and validity of the findings.

45. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as lesbian, gay, or bisexual using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0
45. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

45. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	As an auditor, my corroboration strategies to determine if the specific population exists within the audited facility include multiple layers of verification: Information from the PREA Audit Questionnaire (PAQ): I analyze data provided in the PAQ, which includes demographic information, incident reports, and other relevant statistics about the resident population. Onsite Documentation Review: During the onsite visit, I review various documentation, such as intake forms, resident rosters, medical records, incident reports, and any other relevant documents that can provide insight into the demographics and specific populations within the facility. Interviews and Discussions: I conduct interviews and hold discussions with a range of individuals, including staff, inmates/ residents, and detainees. These conversations provide firsthand accounts and personal insights that complement the data collected from the PAQ and documentation. Staff members often have valuable insights about the population's dynamics and any specific needs or issues that might not be captured in written records. Observation: While onsite, I observe the facility’s operations, resident interactions, and living conditions. This helps corroborate the information obtained from documents and interviews and provides a more holistic understanding of the facility’s environment. By combining these methods, I ensure that the identification and understanding of the population within the facility are accurate and comprehensive. This multi-faceted approach allows me to cross-reference data from various sources, thus increasing the reliability and validity of the findings.

46. Enter the total number of interviews conducted with inmates/residents/ detainees who identify as transgender or intersex using the "Transgender and Intersex Inmates; Gay, Lesbian, and Bisexual Inmates" protocol:	0
46. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

46. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	As an auditor, my corroboration strategies to determine if the specific population exists within the audited facility include multiple layers of verification: Information from the PREA Audit Questionnaire (PAQ): I analyze data provided in the PAQ, which includes demographic information, incident reports, and other relevant statistics about the resident population. Onsite Documentation Review: During the onsite visit, I review various documentation, such as intake forms, resident rosters, medical records, incident reports, and any other relevant documents that can provide insight into the demographics and specific populations within the facility. Interviews and Discussions: I conduct interviews and hold discussions with a range of individuals, including staff, inmates/ residents, and detainees. These conversations provide firsthand accounts and personal insights that complement the data collected from the PAQ and documentation. Staff members often have valuable insights about the population's dynamics and any specific needs or issues that might not be captured in written records. Observation: While onsite, I observe the facility’s operations, resident interactions, and living conditions. This helps corroborate the information obtained from documents and interviews and provides a more holistic understanding of the facility’s environment. By combining these methods, I ensure that the identification and understanding of the population within the facility are accurate and comprehensive. This multi-faceted approach allows me to cross-reference data from various sources, thus increasing the reliability and validity of the findings.
47. Enter the total number of interviews conducted with inmates/residents/ detainees who reported sexual abuse in this facility using the "Inmates who Reported a Sexual Abuse" protocol:	1

48. Enter the total number of interviews conducted with inmates/residents/ detainees who disclosed prior sexual victimization during risk screening using the "Inmates who Disclosed Sexual Victimization during Risk Screening" protocol:	0
48. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

48. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	As an auditor, my corroboration strategies to determine if the specific population exists within the audited facility include multiple layers of verification: Information from the PREA Audit Questionnaire (PAQ): I analyze data provided in the PAQ, which includes demographic information, incident reports, and other relevant statistics about the resident population. Onsite Documentation Review: During the onsite visit, I review various documentation, such as intake forms, resident rosters, medical records, incident reports, and any other relevant documents that can provide insight into the demographics and specific populations within the facility. Interviews and Discussions: I conduct interviews and hold discussions with a range of individuals, including staff, inmates/ residents, and detainees. These conversations provide firsthand accounts and personal insights that complement the data collected from the PAQ and documentation. Staff members often have valuable insights about the population's dynamics and any specific needs or issues that might not be captured in written records. Observation: While onsite, I observe the facility’s operations, resident interactions, and living conditions. This helps corroborate the information obtained from documents and interviews and provides a more holistic understanding of the facility’s environment. By combining these methods, I ensure that the identification and understanding of the population within the facility are accurate and comprehensive. This multi-faceted approach allows me to cross-reference data from various sources, thus increasing the reliability and validity of the findings.

49. Enter the total number of interviews conducted with inmates/residents/ detainees who are or were ever placed in segregated housing/isolation for risk of sexual victimization using the "Inmates Placed in Segregated Housing (for Risk of Sexual Victimization/Who Allege to have Suffered Sexual Abuse)" protocol:	0
49. Select why you were unable to conduct at least the minimum required number of targeted inmates/residents/ detainees in this category:	☒ Facility said there were "none here" during the onsite portion of the audit and/or the facility was unable to provide a list of these inmates/residents/detainees. ☐ The inmates/residents/detainees in this targeted category declined to be interviewed.

49. Discuss your corroboration strategies to determine if this population exists in the audited facility (e.g., based on information obtained from the PAQ; documentation reviewed onsite; and discussions with staff and other inmates/residents/detainees).	As an auditor, my corroboration strategies to determine if the specific population exists within the audited facility include multiple layers of verification: Information from the PREA Audit Questionnaire (PAQ): I analyze data provided in the PAQ, which includes demographic information, incident reports, and other relevant statistics about the resident population. Onsite Documentation Review: During the onsite visit, I review various documentation, such as intake forms, resident rosters, medical records, incident reports, and any other relevant documents that can provide insight into the demographics and specific populations within the facility. Interviews and Discussions: I conduct interviews and hold discussions with a range of individuals, including staff, inmates/ residents, and detainees. These conversations provide firsthand accounts and personal insights that complement the data collected from the PAQ and documentation. Staff members often have valuable insights about the population's dynamics and any specific needs or issues that might not be captured in written records. Observation: While onsite, I observe the facility's operations, resident interactions, and living conditions. This helps corroborate the information obtained from documents and interviews and provides a more holistic understanding of the facility's environment. By combining these methods, I ensure that the identification and understanding of the population within the facility are accurate and comprehensive. This multi-faceted approach allows me to cross-reference data from various sources, thus increasing the reliability and validity of the findings.
50. Provide any additional comments regarding selecting or interviewing targeted inmates/residents/detainees (e.g., any populations you oversampled, barriers to completing interviews):	The auditor conducted interviews on all identified targeted residents.

Staff, Volunteer, and Contractor Interviews

Random Staff Interviews

51. Enter the total number of RANDOM STAFF who were interviewed:	10
52. Select which characteristics you considered when you selected RANDOM STAFF interviewees: (select all that apply)	[x] Length of tenure in the facility [x] Shift assignment [x] Work assignment [x] Rank (or equivalent) [ ] Other (e.g., gender, race, ethnicity, languages spoken) [ ] None
53. Were you able to conduct the minimum number of RANDOM STAFF interviews?	○ Yes ● No
53. Select the reason(s) why you were unable to conduct the minimum number of RANDOM STAFF interviews: (select all that apply)	[ ] Too many staff declined to participate in interviews. [ ] Not enough staff employed by the facility to meet the minimum number of random staff interviews (Note: select this option if there were not enough staff employed by the facility or not enough staff employed by the facility to interview for both random and specialized staff roles). [x] Not enough staff available in the facility during the onsite portion of the audit to meet the minimum number of random staff interviews. [ ] Other

54. Provide any additional comments regarding selecting or interviewing random staff (e.g., any populations you oversampled, barriers to completing interviews, barriers to ensuring representation):	All direct care staff who were onsite during the onsite audit process were interviewed.

Specialized Staff, Volunteers, and Contractor Interviews

Staff in some facilities may be responsible for more than one of the specialized staff duties. Therefore, more than one interview protocol may apply to an interview with a single staff member and that information would satisfy multiple specialized staff interview requirements.

55. Enter the total number of staff in a SPECIALIZED STAFF role who were interviewed (excluding volunteers and contractors):	22
56. Were you able to interview the Agency Head?	● Yes ○ No
57. Were you able to interview the Warden/Facility Director/Superintendent or their designee?	● Yes ○ No
58. Were you able to interview the PREA Coordinator?	● Yes ○ No
59. Were you able to interview the PREA Compliance Manager?	● Yes ○ No ○ NA (NA if the agency is a single facility agency or is otherwise not required to have a PREA Compliance Manager per the Standards)

60. Select which SPECIALIZED STAFF roles were interviewed as part of this audit from the list below: (select all that apply)	☐ Agency contract administrator ☒ Intermediate or higher-level facility staff responsible for conducting and documenting unannounced rounds to identify and deter staff sexual abuse and sexual harassment ☐ Line staff who supervise youthful inmates (if applicable) ☐ Education and program staff who work with youthful inmates (if applicable) ☐ Medical staff ☒ Mental health staff ☐ Non-medical staff involved in cross-gender strip or visual searches ☒ Administrative (human resources) staff ☐ Sexual Assault Forensic Examiner (SAFE) or Sexual Assault Nurse Examiner (SANE) staff ☒ Investigative staff responsible for conducting administrative investigations ☒ Investigative staff responsible for conducting criminal investigations ☒ Staff who perform screening for risk of victimization and abusiveness ☐ Staff who supervise inmates in segregated housing/residents in isolation ☒ Staff on the sexual abuse incident review team ☒ Designated staff member charged with monitoring retaliation ☒ First responders, both security and non-security staff ☒ Intake staff

	☒ Other
If "Other," provide additional specialized staff roles interviewed:	DYS Advocate
61. Did you interview VOLUNTEERS who may have contact with inmates/ residents/detainees in this facility?	○ Yes ● No
62. Did you interview CONTRACTORS who may have contact with inmates/ residents/detainees in this facility?	● Yes ○ No
62. Enter the total number of CONTRACTORS who were interviewed:	1
62. Select which specialized CONTRACTOR role(s) were interviewed as part of this audit from the list below: (select all that apply)	☐ Security/detention ☒ Education/programming ☐ Medical/dental ☐ Food service ☐ Maintenance/construction ☐ Other
63. Provide any additional comments regarding selecting or interviewing specialized staff.	While the facility listed a volunteer, they were not active during the time of the audit process.

SITE REVIEW AND DOCUMENTATION SAMPLING

Site Review

PREA Standard 115.401 (h) states, "The auditor shall have access to, and shall observe, all areas of the audited facilities." In order to meet the requirements in this Standard, the site review portion of the onsite audit must include a thorough examination of the entire facility. The site review is not a casual tour of the facility. It is an active, inquiring process that includes talking with staff and inmates to determine whether, and the extent to which, the audited facility's practices demonstrate compliance with the Standards. Note: As you are conducting the site review, you must document your tests of critical functions, important information gathered through observations, and any issues identified with facility practices. The information you collect through the site review is a crucial part of the evidence you will analyze as part of your compliance determinations and will be needed to complete your audit report, including the Post-Audit Reporting Information.

Question	Response
64. Did you have access to all areas of the facility?	(●) Yes ( ) No

Was the site review an active, inquiring process that included the following:

Question	Response
65. Observations of all facility practices in accordance with the site review component of the audit instrument (e.g., signage, supervision practices, cross-gender viewing and searches)?	(●) Yes ( ) No
66. Tests of all critical functions in the facility in accordance with the site review component of the audit instrument (e.g., risk screening process, access to outside emotional support services, interpretation services)?	(●) Yes ( ) No
67. Informal conversations with inmates/ residents/detainees during the site review (encouraged, not required)?	(●) Yes ( ) No
68. Informal conversations with staff during the site review (encouraged, not required)?	(●) Yes ( ) No

69. Provide any additional comments regarding the site review (e.g., access to areas in the facility, observations, tests of critical functions, or informal conversations).	During the site review, comprehensive access was granted to all areas of the facility, allowing for a thorough examination of the environment and operations. Key observations included the following: Facility Access: Unrestricted access to various sections of the facility was provided, facilitating a detailed assessment of living conditions, security measures, and common areas. Operational Observations: Several critical functions were tested and observed, including emergency response protocols, security checks, and daily operational routines. These tests demonstrated the facility's preparedness and adherence to established standards. Interactions and Informal Conversations: Informal conversations with staff, residents, and detainees provided additional insights into the daily operations and the overall atmosphere of the facility. These interactions were valuable in corroborating data obtained from documentation and formal interviews. General Observations: The site review highlighted both strengths and areas for improvement within the facility. Observations on cleanliness, maintenance, and the behavior of staff and residents contributed to a comprehensive understanding of the facility's current state.

Documentation Sampling

Where there is a collection of records to review-such as staff, contractor, and volunteer training records; background check records; supervisory rounds logs; risk screening and intake processing records; inmate education records; medical files; and investigative files-auditors must self-select for review a representative sample of each type of record.

70. In addition to the proof documentation selected by the agency or facility and provided to you, did you also conduct an auditor-selected sampling of documentation?	(●) Yes ( ) No

71. Provide any additional comments regarding selecting additional documentation (e.g., any documentation you oversampled, barriers to selecting additional documentation, etc.).	During the audit process, I took several steps to ensure that the documentation reviewed was thorough and representative of the facility's operations: Oversampling Documentation: In certain instances, I oversampled documentation to gain a deeper understanding of specific areas. For example, I reviewed an increased number of training records and unannounced rounds to identify any recurring patterns or issues that might not be evident from a smaller sample size. Barriers to Selecting Additional Documentation: While the facility provided comprehensive access to most documents, there were some challenges encountered: Document Availability: In a few cases, some documents were not immediately available, however provided by the final audit report. Mitigation Strategies: To address these barriers, I implemented several strategies: Prioritization: I prioritized reviewing documents that were most critical to the audit's objectives and sought summaries or overviews where full documents were not accessible. Supplementary Interviews: When documentation was not fully available, I supplemented the review with additional interviews and discussions with staff and residents to fill in the gaps. Request for Additional Information: I requested additional information or clarifications as needed to ensure that the audit findings were accurate and comprehensive. These steps were taken to ensure a thorough and balanced review of the facility’s documentation, ultimately contributing to a more accurate assessment.

SEXUAL ABUSE AND SEXUAL HARASSMENT ALLEGATIONS AND INVESTIGATIONS IN THIS FACILITY

Sexual Abuse and Sexual Harassment Allegations and Investigations Overview

Remember the number of allegations should be based on a review of all sources of allegations (e.g., hotline, third-party, grievances) and should not be based solely on the number of investigations conducted. Note: For question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, or detainee sexual abuse allegations and investigations, as applicable to the facility type being audited.

72. Total number of SEXUAL ABUSE allegations and investigations overview during the 12 months preceding the audit, by incident type:

	# of sexual abuse allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual abuse	0	0	1	0
Staff-on-inmate sexual abuse	0	0	0	0
Total	0	0	1	0

73. Total number of SEXUAL HARASSMENT allegations and investigations overview during the 12 months preceding the audit, by incident type:

	# of sexual harassment allegations	# of criminal investigations	# of administrative investigations	# of allegations that had both criminal and administrative investigations
Inmate-on-inmate sexual harassment	5	0	5	0
Staff-on-inmate sexual harassment	0	0	0	0
Total	5	0	5	0

Sexual Abuse and Sexual Harassment Investigation Outcomes

Sexual Abuse Investigation Outcomes

Note: these counts should reflect where the investigation is currently (i.e., if a criminal investigation was referred for prosecution and resulted in a conviction, that investigation outcome should only appear in the count for “convicted.”) Do not double count. Additionally, for question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, and detainee sexual abuse investigation files, as applicable to the facility type being audited.

74. Criminal SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

	Ongoing	Referred for Prosecution	Indicted/ Court Case Filed	Convicted/ Adjudicated	Acquitted
Inmate-on-inmate sexual abuse	0	0	0	0	0
Staff-on-inmate sexual abuse	0	0	0	0	0
Total	0	0	0	0	0

75. Administrative SEXUAL ABUSE investigation outcomes during the 12 months preceding the audit:

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual abuse	0	0	1	0
Staff-on-inmate sexual abuse	0	0	0	0
Total	0	0	1	0

Sexual Harassment Investigation Outcomes

Note: these counts should reflect where the investigation is currently. Do not double count. Additionally, for question brevity, we use the term “inmate” in the following questions. Auditors should provide information on inmate, resident, and detainee sexual harassment investigation files, as applicable to the facility type being audited.

76. Criminal SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

	Ongoing	Referred for Prosecution	Indicted/ Court Case Filed	Convicted/ Adjudicated	Acquitted
Inmate-on-inmate sexual harassment	0	0	0	0	0
Staff-on-inmate sexual harassment	0	0	0	0	0
Total	0	0	0	0	0

77. Administrative SEXUAL HARASSMENT investigation outcomes during the 12 months preceding the audit:

	Ongoing	Unfounded	Unsubstantiated	Substantiated
Inmate-on-inmate sexual harassment	0	0	3	2
Staff-on-inmate sexual harassment	0	0	0	0
Total	0	0	3	2

Sexual Abuse and Sexual Harassment Investigation Files Selected for Review

Sexual Abuse Investigation Files Selected for Review

78. Enter the total number of SEXUAL ABUSE investigation files reviewed/ sampled:	1

Question	Response
79. Did your selection of SEXUAL ABUSE investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	○ Yes ● No ○ NA (NA if you were unable to review any sexual abuse investigation files)
Inmate-on-inmate sexual abuse investigation files	
80. Enter the total number of INMATE-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	1
81. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	○ Yes ● No ○ NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
82. Did your sample of INMATE-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	● Yes ○ No ○ NA (NA if you were unable to review any inmate-on-inmate sexual abuse investigation files)
Staff-on-inmate sexual abuse investigation files	
83. Enter the total number of STAFF-ON-INMATE SEXUAL ABUSE investigation files reviewed/sampled:	0
84. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include criminal investigations?	○ Yes ● No ○ NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)

85. Did your sample of STAFF-ON-INMATE SEXUAL ABUSE investigation files include administrative investigations?	○ Yes ● No ○ NA (NA if you were unable to review any staff-on-inmate sexual abuse investigation files)
Sexual Harassment Investigation Files Selected for Review	
86. Enter the total number of SEXUAL HARASSMENT investigation files reviewed/sampled:	5
87. Did your selection of SEXUAL HARASSMENT investigation files include a cross-section of criminal and/or administrative investigations by findings/outcomes?	○ Yes ● No ○ NA (NA if you were unable to review any sexual harassment investigation files)
Inmate-on-inmate sexual harassment investigation files	
88. Enter the total number of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	5
89. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT files include criminal investigations?	○ Yes ● No ○ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)
90. Did your sample of INMATE-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	● Yes ○ No ○ NA (NA if you were unable to review any inmate-on-inmate sexual harassment investigation files)

Staff-on-inmate sexual harassment investigation files	
91. Enter the total number of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files reviewed/sampled:	0
92. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include criminal investigations?	○ Yes ● No ○ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
93. Did your sample of STAFF-ON-INMATE SEXUAL HARASSMENT investigation files include administrative investigations?	○ Yes ● No ○ NA (NA if you were unable to review any staff-on-inmate sexual harassment investigation files)
94. Provide any additional comments regarding selecting and reviewing sexual abuse and sexual harassment investigation files.	It should be noted that one of the reported allegations of sexual harassment was also reviewed for sexual abuse.

SUPPORT STAFF INFORMATION

DOJ-certified PREA Auditors Support Staff	
95. Did you receive assistance from any DOJ-CERTIFIED PREA AUDITORS at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	○ Yes ● No

Non-certified Support Staff	
96. Did you receive assistance from any NON-CERTIFIED SUPPORT STAFF at any point during this audit? REMEMBER: the audit includes all activities from the pre-onsite through the post-onsite phases to the submission of the final report. Make sure you respond accordingly.	○ Yes ● No

AUDITING ARRANGEMENTS AND COMPENSATION

97. Who paid you to conduct this audit?	● The audited facility or its parent agency ○ My state/territory or county government employer (if you audit as part of a consortium or circular auditing arrangement, select this option) ○ A third-party auditing entity (e.g., accreditation body, consulting firm) ○ Other

Standards
Auditor Overall Determination Definitions
• Exceeds Standard (Substantially exceeds requirement of standard) • Meets Standard (substantial compliance; complies in all material ways with the stand for the relevant review period) • Does Not Meet Standard (requires corrective actions)
Auditor Discussion Instructions
Auditor discussion, including 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 standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.

115.311	Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: (Policies, directives, forms, files, records, etc.) a. Policy 13.8.1: 13.0 Juvenile Rights (Protection from Sexual Abuse and Assault) b. Pre-Audit Questionnaire (PAQ) c. Agency Organization Chart 2. Interviews: a. PREA coordinator b. Director c. PREA Compliance Manager

Findings (By Provision):

115.311 (a). An agency shall have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment and outlining the agency's approach to preventing, detecting, and responding to such conduct.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

· As reported in the PAQ, the agency has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract.

· Policy 13.8.1: 13.0 Juvenile Rights (Protection from Sexual Abuse and Assault) provides:

o The agencies written policy mandating zero tolerance of all forms of sexual abuse and sexual harassment in its facilities.

o Outlines how it will implement the agencies zero tolerance approach to preventing, detecting, and responding to sexual abuse and sexual harassment.

o Provides definitions of prohibited behaviors regarding sexual abuse and sexual harassment.

o Includes sanctions for those found to have participated in prohibited behaviors.

o Includes a description of agency strategies to reduce and prevent sexual abuse and sexual harassment of residents.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision.

115.311 (b). An agency shall employ or designate an upper-level, agency-wide PREA coordinator with sufficient time and authority to develop, implement, and oversee agency efforts to comply with the PREA standards in all of its facilities.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the facility employs an upper level, agency wide PREA coordinator/Director/Lieutenant, Casey Flatt. According to the agency organizational chart, the agency PREA coordinator reports to the Major. It was further reported that the PREA Coordinator has sufficient time and authority to develop, implement, and

	oversee agency efforts to comply with the PREA standards in all of its facilities. The agency/facility has PREA policies which ensure the sexual safety of facility residents and staff. The policy includes zero-tolerance philosophy from the agency central office through the front-line staff in its facilities. The agency/facility PREA coordinator has direct access to the head of the agency and regular communication with the senior leadership team. Agency Organization Chart Interviews: PREA Coordinator: The interviewed staff reported that they have time to manage their PREA-related responsibilities. There are two PREA Compliance Manager and interactions occur every other day. If there is an identified issue it will be discussed with the Program Coordinator/PREA Manager, Executive Director and Clinical Services Coordinator. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.311 (c): Where an agency operates more than one facility, each facility shall designate a PREA compliance manager with sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards. Compliance Determination: According to the PAQ, the facility has a designated PREA compliance manager. The Compliance Manager is the Program Director and reports to the Executive Director. Interviews: PREA Compliance Manager: The interviewed staff reported that they have enough time to manage all of the PREA-related responsibilities. The PREA standards are coordinated by continued training. Training on subjects like intake, and unannounced rounds. If issues are identified they will be discussed with the PREA Coordinator and the Executive Director. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility

documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.312 Contracting with other entities for the confinement of residents

Auditor Overall Determination: Meets Standard

Auditor Discussion

The following evidence was analyzed in making compliance determination:

1. Documents: (Policies, directives, forms, files, records, etc.):

a. Pre-Audit Questionnaire (PAQ)

2. Interviews:

a. Agency contract administer-1

Findings (By Provision):

115.312 (a). A public agency that contracts for the confinement of its residents with private agencies or other entities, including other government agencies, shall include in any new contract or contract renewal the entity's obligation to adopt and comply with the PREA standards.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

The Pre-Audit Questionnaire (PAQ) indicated that the agency has entered into or renewed contracts for the confinement of residents on or after August 20, 2012, or since the last PREA audit. The number of contracts for the confinement of residents that the agency entered into or renewed with private entities or other government agencies on or after August 20, 2012 or since the last PREA audit, whichever is later:1.

Upon further review, the agency/facility does not contract with another entity for the confinement of its Residents. The agency is a party to a contract to temporarily hold residents for state youth or other counties.

Corrective Action:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined

that the agency and facility is fully compliant with this provision.

115.312 (b). Any new contract or contract renewal shall provide for agency contract monitoring to ensure that the contractor is complying with the PREA standards.

Compliance Determinations:

The facility has demonstrated substantial compliance with this provision of the standard because:

As reported in the PAQ, On or after August 20, 2012, or since the last PREA audit, whichever is later, the number of the contracts referenced in 115.312 (a) that DO NOT require the agency to monitor contractor's compliance with PREA Standards: 0.

The agency/facility does not contract with another entity for the confinement of its Residents.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision.

Overall Findings:

The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.313 Supervision and monitoring

Auditor Overall Determination: Meets Standard

Auditor Discussion

The following evidence was analyzed in making compliance determination:

1. Documents: (Policies, directives, forms, files, records, etc.):

a. Pre-Audit Questionnaire (PAQ)

a. Policy: Protection from Sexual Abuse and Assault

b. Staffing Plan (2024)

c. Deviation to the Staffing Plan (since site opened)

	d. Unannounced Rounds (3) 2. Interviews: a. Director b. PREA coordinator c. Intermediate or higher-level staff (1) 3. Corrective Action: a. Training for supervisor staff on conducting unannounced rounds-Complete b. Documentation of at least two months of unannounced rounds on all shits (3 months) c. Updated Policy-Complete Findings (By Provision): 115.313 (a). The agency shall comply with the staffing plan except during limited and discrete exigent circumstances and shall fully document deviations from the plan during such circumstances. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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. Since August 20, 2012, or last PREA audit, whichever is later, the average daily number of residents: 13. Since August 20, 2012, or last PREA audit, whichever is later, the average daily number of residents on which the staffing plan was predicated: 0. Documented annual staffing plan provides a staffing plan that provides for adequate levels of staffing (2024 Annual Staffing Plan). It should be noted that the program opened in 2023. The facility has cameras to supplement supervision of residents. They are in and out of the facility to help eliminate blind spots and to assist in monitoring residents. Site Review: · The auditor observed staffing patterns during every shift, including: o In the housing units: During the evening shift there were four staff, three of which were directly engaged with the residents for 15 residents. During the day shift the auditor observed three staff with the 15 residents.

	o There were no youth in isolated areas like administrative/disciplinary segregation and protective custody. o The auditor observed residents in the classroom. The residents were in the classroom with a contracted teacher and a direct care staff. Seven were in a room with one teacher and one direct care staff; and five were in a room with one teacher and one direct care staff. Two other residents were meeting one on one with a therapist. The therapist's door was open as if it was an informal meeting. One additional staff was placed in the hallway as a rover. o There were no areas identified in the staffing plan that sexual abuse is known to be more likely to occur according to the staffing plan. o The auditor observed that there were at least three staff for 15 residents in the day and evening hours in the housing units. · Overall, the staff were in direct line site observation on the unit. During the night shift the auditor observed that the residents were walking in and out of rooms. The auditor reviewed the video footage to determine if the residents were going in and out of the day room or housing rooms while on the unit. · All locations in the housing area were under direct care staff or camera observation. The restroom and bedrooms do not have cameras, however at least one staff member was positioned in the hallway at all times. There are cameras in the hallway to monitor residents and staff going in and out of rooms. It should also be known that the cameras have sight and sound access. · The auditor observed via camera footage staff conducting 15-minute rover checks in the housing area of all residents. · The auditor observed the placement of cameras throughout the facility. In the housing area, the cameras are placed in common spaces and in the hallways. There are also cameras also mounted on the outside of the buildings. The cameras are in an offsite location; but are not under current surveillance. The cameras are reviewed by the PREA Coordinator on a weekly basis. · The auditor did not observe any issues with direct care staffing ratios. There were some other critical positions such as the nurse and case manager that were vacant. Additionally, the auditor should: · Informal conversation occurred with staff. The staff reported that someone is always coming around checking on everyone. This is typically a supervisor. · Informal conversation with staff reported that the facility ensures that staff are always located where the residents are located. The staff did not report any issues with meeting the staffing ratios. Audit Observations and Resident Feedback:

No staffing concerns were identified during the onsite audit. The auditor engaged in informal conversations with on-site staff, who confirmed maintaining a 1:8 staff-to-resident ratio. Residents reported feeling safe, consistently supervised, and never left unsupervised. Additionally, it should be noted that on one housing unit there were three residents on the unit who were having challenges that day at school, the residents were very engaging and provided the auditor with an overview of the unit, how shower sessions are handled, how many staff are typically with them, the facility rules and how to make reports of sexual abuse or sexual harassment.

Interviews:

Director/PREA Compliance Manager: The Director reported that adequate levels for staffing are considered to protect residents against sexual abuse. The level of staffing is two at all times 1:8; having three youth services workers per shift at all times. Video monitoring is a part of the plan and reviewed by offsite Administration. The staffing plan is documented and a copy of the schedule is posted by the clock daily. When assessing staffing levels, the following are addressed:

Generally accepted detention practices: 1:8 ratio, staffing is increased if needed.

· Judicial Findings: None

· Inadequacy from federal investigations: None

· Inadequacy from internal or external oversight bodies: None

· All components of the facility's physical plant (including "blind spots" or areas where staff or residents may be isolated); All areas covered with cameras, except for the bathrooms, bedrooms, therapy, private offices, and storage rooms.

· Composition of resident population: we have a process for how residents and staff can enter the bedrooms; we evaluate residents for the prior history and behaviors, and staff is educated on the process.

· The number and placement of supervisory staff: currently one on each shift

· Institution programs: Only education

· Any applicable state or local laws, regulations, or standards: state standards

· The prevalence of substantiated and unsubstantiated incidents of sexual abuse: staffing would be increased if an incident of sexual abuse.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.313 (b). The agency shall comply with the staffing plan except during limited

	and discrete exigent circumstances and shall fully document deviations from the plan during such circumstances. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: According to the PAQ the facility has not deviated from the staffing plan. Deviations to the staffing plan (last 12months): There were no documented deviations in the report. Interviews: Director– Due to the location of the facility, environmental factors such as a storm could hinder staff from getting into work (tree falling, road closures, etc.). Supervisory staff stay onsite if there is inclement weather. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.313 (c). Each secure juvenile facility shall maintain staff ratios of a minimum of 1:8 during resident waking hours and 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances, which shall be fully documented. Only security staff should be included in these ratios. Any facility that, as of the date of publication of this final rule, is not already obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph shall have until October 1, 2017, to achieve compliance. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: According to the PAQ, the facility meets staffing ratios by maintaining the staffing ratios of minimum 2:8 during resident waking hours and 1:8 during resident sleeping hours. As reported, the facility has not deviated from the staff ratios of 1:8 during waking hours and 1:16 during resident sleeping hours. In the past 12 months, the number of times the facility deviated from the staffing ratios of 1:8 security staff during resident waking hours: 0. In the past 12 months, the number of times the facility deviated from the staffing ratios of 1:16 during resident sleeping hours: 0. Deviations to the staffing plan (last 12months): There were no documented

deviations in the report.

Interviews:

Director: The facility is required to meet DCSS standards, including those pertaining to staffing ratios. That ratio is 1:8. Staff is scheduled heavily with three staff for 16 residents. Supervisors verify staffing each shift. There is a medical supervisor who is responsible for coming in if staffing is lower than 3:16.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.313 (d). Whenever necessary, but no less frequently than once each year, for each facility the agency operates, in consultation with the PREA coordinator required by § 115.311, the agency shall assess, determine, and document whether adjustments are needed to: (1) The staffing plan established pursuant to paragraph (a) of this section; (2) Prevailing staffing patterns; (3) The facility's deployment of video monitoring systems and other monitoring technologies; and (3) The resources the facility has available to commit to ensure adherence to the staffing plan.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the facility, in collaboration with the agency’s PREA coordinator; reviews the staffing plan to see whether adjustments are needed to:

o The staffing plan;

o Prevailing staffing patterns

o The deployment of monitoring technology; or

o The allocation of agency or facility resources to commit to the staffing plan to ensure compliance with the staffing plan.

Annual Review of staffing plan (2024)

Interviews:

PREA Coordinator – The interviewed PREA Coordinator reported that adjustments are made as needed besides the annual assessment.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.313 (e). Each secure facility shall implement 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. Such policy and practice shall be implemented for night shifts as well as day shifts. Each secure facility shall have a policy to prohibit 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.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the facility 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. It was further reported that the unannounced rounds covered all shifts.

Policy: Protection from Sexual Abuse and Assault stated that “each facility shall implement a practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment” (p. 11). The policy further states that the rounds shall occur on all shifts and shall be documented.

Supervisor monitoring/unnanounced rounds log (2 months): One full month and two partial months of unnanounced rounds. The rounds provide a detailed description of what was assessed during the rounds and documented in a report.

Interviews:

Intermediate or Higher-Level Staff- The interviewed staff reported that unnanounced rounds are conducted to ensure that residents are on schedule and doing what they are supposed to do. When the rounds are conducted staff do not know when we are coming around. We will come around at random times throughout the day and the night. The rounds are done by walking the facility making sure the youth are secure and things are done as they are supposed to be done. The staff reported that they are always doing rounds but they don’t always document them.

Corrective Actions:

- The facility shall conduct training with the supervisor staff who can conduct unannounced rounds. The facility shall provide documentation of the training and provide it to the auditor. Additionally, the facility shall provide two months of documentation that the rounds are being conducted on all shifts. The documentation shall clearly discuss what is being observed during the rounds.

Corrective Action Taken: While the facility provided documentation of rounds

	conducted in August, the facility shall provide documentation of the consistency of the unannounced rounds for the month of September and October 2024. During the corrective action phase, the facility provided documentation of additional unannounced rounds occurring on all shifts for a three month period of October through December 2025. The documentation was thorough and consistent with the requirements of the provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Upon completing the initial review, it was found that the requested documentation, as per the PREA standard provisions, needs corrective action to address conducting unannounced rounds. The interim report finds the standard non-compliant. The requested documentation was provided no further action needed. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with requirements of the standard.

115.315	**Limits to cross-gender viewing and searches**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents a. Pre-Audit Questionnaire (PAQ) b. Policy 9.6 (Control of Contraband) c. Policy 9.8 (Searches) d. Southeast Alabama Youth Services Searches Form (SAYS) e. YSW Training: Juvenile Searches Agenda f. The Standard Compliance Checklist g. Searches Training Sign In Sheet (6/13/2024)- (3 staff)

	h. Searches Training Sign In Sheet (7/18/2024)- (14 staff) 2. Interviews: a. Random sample of staff - 10 b. Random sample of residents – 10 3. Corrective Action: a. Training-completed b. Policy-completed Findings (By Provision): 115.315 (a). The facility shall 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 or when performed by medical practitioners. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the facility does not conduct cross-gender strip or cross gender visual body cavity searches of residents. In the past 12 months, the number of cross-gender strip or cross-gender visual body cavity searches of residents: 0. Policy 9.8 (Searches) states that "juvenile searches will be conducted by the sex as person being searched. Staff shall not conduct cross-gender pat-down, strip, or body cavity searches except in exigent circumstances by completing SAYS Form 115.315 and submit the form to the PREA Coordinator" (p. 1). The SAYS form provides the documentation for when searches are conducted. The form covers Pat Down, Strip, Body Cavity, and Cross-Gender Searches. Furthermore, the form indicates the reason for the resident information, reason for the search, who conducted the search and when. Site Review: · The site does not conduct strip searches. Informal conversation with the evening staff, shower the auditor how a pat down search is conducted. Staff also reported that when residents first arrive, a pat down search will occur. · Search Observations: o The auditor did not observe any searches being conducted during the site review. · Staff Practices:

	o In informal conversations, staff confirmed that they are not permitted to conduct cross-gender strip or pat-down searches. They emphasized that they do not place their hands on residents, and any searches conducted during intake are performed by staff of the same gender as the resident. · Resident Feedback: o Residents reported that they have never experienced a search by female staff. They also stated that no staff member has ever conducted a strip or pat-down search on them. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.315 (b). The agency shall not conduct cross-gender pat-down searches except in exigent circumstances. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The facility reported in the PAQ that it does not permit cross-gender pat-down searches of residents, absent exigent circumstances. In the past 12 months, the number of cross-gender pat-down searches of residents: 0. In the past 12 months, the number of cross-gender pat-down searches of residents that did not involve exigent circumstance(s): 0. Policy 9.8 (Searches) states that "juvenile searches will be conducted by the sex as person being searched. Staff shall not conduct cross-gender pat-down, strip, or body cavity searches except in exigent circumstances by completing SAYS Form 115.315 and submit the form to the PREA Coordinator" (p. 1). Policy 9.6 (Control of Contraband Searches) provides guidance on how and when a search shall be conducted. The facility does not permit cross-gender part-down searches and has a policy against this practice. This facility is males only. Interviews: Random Sample of Staff: All (11) staff onsite representation all shifts were interviewed during the onsite audit. The staff reported that they are not allowed to do a cross-gender pat down search. One of the night shift staff reported that there are no female staff on his shift. Residents(s) in custody Interview Questionnaire: All of the interviewed residents

reported that they have never been pat down searched by opposite gender staff.

Corrective Actions:

N/A. There are no corrective actions.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision.

115.315 (c). The facility shall document and justify all cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

The facility indicated in their response to the PAQ that the facility policy requires that all cross-gender strip searches, cross-gender visual body cavity searches, and cross-gender pat-down searches be documented and justified.

Policy 9.8 (Searches) states that "juvenile searches will be conducted by the sex as person being searched. Staff shall not conduct cross-gender pat-down, strip, or body cavity searches except in exigent circumstances by completing SAYS Form 115.315 and submit the form to the PREA Coordinator" (p. 1).

Policy 9.6 (Control of Contraband Searches) provides guidance on how and when a search shall be conducted.

Corrective Actions:

N/A. There are no corrective actions.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision.

115.315 (d). The facility shall implement 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. Such policies and procedures shall require staff of the opposite gender to announce their presence when entering a resident housing unit. In facilities (such as group homes) that do not contain discrete housing units, staff of the opposite gender shall be required to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As indicated in the PAQ, the facility has implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks, along with policies and procedures that advise staff.

Policy 9.6 (Control of Contraband) indicates that the "juvenile shall be able 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" (p. 1).

Site Review:

· The auditor observed areas where a resident may be in a state of undress, such as showering, using the toilet, and/or changing their clothes.

o All areas include:

§ Inside housing units. Residents change clothes, use the restroom and shower in the hallway bathroom. The bathroom has shower curtains and staff are positioned only at the door. The residents reported that female staff do not come in the bathroom area. There are no cameras or surveillance mirrors in that area. The auditor observed that the shower curtains may not be PREA compliant as it leaves room for a blind spot or restriction in observing the number of residents in the single stall at a time. The bathrooms had for toilets with doors and four shower stalls. Each toilet and shower allowed for individual access.

§ Outside of the housing units there were toilets and showers in the medical area and toilets available in common areas such as the education hallway. The medical toilet and shower has limited access and use.

· Cross-Gender Observation and Privacy:

o The auditor assessed whether non-medical staff of the opposite gender could view residents in a state of undress, including from different angles or via mirrors. The facility's design ensures that staff do not have a direct line of sight into areas where residents undress or use the toilet. Mirrors are only present above the sinks in the bathroom.

o The auditor also reviewed the electronic surveillance monitoring areas and confirmed that management staff do not have the ability to observe residents in restroom areas where they could be undressed. No mirrors are used in the housing area for surveillance purposes, and the facility does not employ any software or physical mechanisms (e.g., pixelation, post-its, tape) to obscure cross-gender viewing. Observation of the camera system occurred in the Directors Office.

· The site does not have a centralized control room. There is an electronic observation system that is monitored periodically from the agency headquarters. Video footage is available for 12 days. The auditor observed a historical record of video footage in conjunction with the agency PREA Coordinator.

· Staff and Resident Feedback:

o In informal conversations, direct care staff reported that residents shower and change only in the bathroom, with typically only allowing one resident in at a time. If two residents are in the area they cannot use adjacent stalls. Staff emphasized that residents must remain fully dressed at all times.

o Residents reported that staff never see them in a state of undress and that they are expected to be fully clothed at all times. They noted that it is strictly prohibited to walk around without a shirt.

· Opposite Gender Announcements:

o During the site review, the auditor observed that staff did not make an opposite-gender announcement when entering the housing area or restroom. However, it was noted that opposite-gender staff did not enter the restroom area when residents were present, and residents had to request permission to enter the restroom.

o The auditor also observed that opposite-gender staff were already in the housing area before the auditor's entrance.

o In informal conversations, staff reported that opposite-gender announcements are consistently made. Residents confirmed this, stating that either the opposite-gender staff or a male staff member announces when an opposite-gender staff enters the building. Residents also noted that opposite-gender staff typically avoid entering the restroom area.

Interviews:

Random Sample of Staff: All of the interviewed staff reported that residents(s) in custody can dress, shower, and use the toilet without being viewed by staff of the opposite gender and that female presence on housing units is announced. Eight out of ten of the interviewed staff reported that they make an announcement when they enter the housing unit. Several staff members reported that there are no opposite gender staff on their shift and one staff stated that announcements are not done consistently.

Residents(s) in custody Interview Questionnaire: All of the interviewed residents reported that female staff announce themselves when entering the housing area. All of the residents reported that they are never naked in full view of the opposite gender staff. The residents further reported that they are not naked in front of any staff. They are expected to change in the shower area.

Corrective Actions:

· Training: Recommend retraining staff to include supervisors on the requirement to make announcements when opposite gender staff come on the housing unit.

Corrective Action Taken: The facility provided documentation, indicating that on 10/

	1/2024 staff were provided refresher training on: Opposite Gender Announcements, Evidence Protocol, Age of Consent and Third-Party Reporting. According to the roster 17 staff received training. No further action required. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.315 (e.) The facility shall not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Per the PAQ, the facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. There were no reported searches that were conducted in the last 12 months. Interviews: Random Sample of Staff: Ten staff interviews were conducted, covering staff from all shifts. Nine of the interviewed staff reported that they are not allowed to search or physically examine a transgender or intersex individual in custody for the purpose of determining the individual in custody's genital status. Corrective Actions: · Policy: Policy language does not address the above-mentioned provision. Corrective Action Implemented: Policy Southeast Alabama Youth Services policy was updated to state "The facility shall not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status. If the resident's genital status is unknown, it may be determined 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" (p. 2). Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.315 (f). The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex residents, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

YSW Training: Juvenile Searches Agenda (June 13, 2024). According to the agenda agency policy along with the PREA Resource Center video (Guidance in Cross-Gender and Transgender Pat Searches, the Moss Group, Inc.); along with examples and how to documents aid searches.

The Standard Compliance Checklist provides staff with an overview of the PREA standards and PREA policy related to searches).

Searches Training Sign In Sheet (6/13/2024)- (3 staff). Provides documentation of staff receipt of searches training.

Searches Training Sign In Sheet (7/18/2024)- (14 staff). Provides documentation of staff receipt of searches training.

Interviews

Random Sample of Staff: Of the ten staff interviewed, several reported that pat searches are not allowed, several stated that cross gender searches are not allowed, and most staff stated that they were trained on the searches policy via a video. Most staff were new and recently trained.

Corrective Actions:

N/A. There are no corrective actions.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision.

Overall Findings:

The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.316 Residents with disabilities and residents who are limited English proficient

Auditor Overall Determination: Meets Standard

Auditor Discussion

The following evidence was analyzed in making compliance determination:

1. Documents:

a. Pre-Audit Questionnaire (PAQ)

b. Policy 13.1.8 (Protection from Sexual Abuse and Assault)

c. Interpreter Services Agreement (Dated 4/30/2024)

2. Interviews:

a. Random sample of staff -10

Findings (By Provision):

115.316 (a). The agency shall take appropriate steps to ensure that residents with disabilities (including, for example, residents who are deaf or hard of hearing, those who are blind or have low vision, or those who have intellectual, psychiatric, or speech 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. Such steps shall include, when necessary to ensure effective communication with residents who are deaf or hard of hearing, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. In addition, the agency shall 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, limited reading skills, or who are blind or have low vision. An agency is not required to take actions that it can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity, or in undue financial and administrative burdens, as those terms are used in regulations promulgated under title II of the Americans With Disabilities Act, 28 CFR 35.164.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the facility, 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.

Policy 13.8.1 (Protection from Sexual Abuse and Assault) states that “each facility shall take appropriate steps to ensure that juveniles with disabilities have an equal opportunity to participate in or benefit from all aspects of SAYS' s efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Such steps shall include, when necessary to ensure effective communication with juveniles who are deaf or hard of hearing, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. In addition, facilities shall ensure that written

materials are provided in formats or through methods that ensure effective communication with juveniles with disabilities, including juveniles who have intellectual disabilities, limited reading skills, or who are blind or have low vision" (p.4).

Contract (Alabama Institute for Deaf and Bling): To ensure effective communication with residents or residents who are deaf or hard of hearing, the agency provide access to interpreters who can interpret effectively, accurately, and impartially both receptively and expressively, using any necessary specialized vocabulary.

The agency uses a combination of written material, video and brochures (standard 115.333) to educate the residents on sexual abuse and sexual harassment in a confinement setting.

Site Review

· While the facility did not have any residents who were limited English Speaking, the auditor was able to test securing interpretation services on-demand.

o The auditor contacted the language line and spoke to the staff on the process to access on demand languages. The staff walked the auditor through the process so the site would not be charged for the use of services.

· The interpreter services are available 24/7 with staff assistance to access the line.

· As described by the Director the language line services would be accessed and the use of the interpreter would occur in a closed-door setting.

Additionally:

· During informal and formal conversation with the director who was assisting with intake in the absence of staff, it was reported that if interpreter services were needed, they would coordinate to ensure services were received. As of the facility opening, they have not had to access interpreter services.

Interviews:

Agency Head-The interviewed agency head reported that the agency does have established procedures to provide residents with disabilities and residents who are limited English proficiency. English language proficiency is identified at Intake. Those who are not proficient in English or have limited proficiency will be provided an interpreter specific to their language needs per MOU. A Screening of Vulnerability is conducted at Intake and appropriate housing is determined based on the outcome of the screen.

Corrective Actions:

N/A. There are no corrective actions.

Based on review and analysis of the available evidence, the auditor has determined

	that the agency and facility is fully compliant with this provision. 115.316 (b). The agency shall 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, including steps to provide interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the facility 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. Contract (Alabama Institute for Deaf and Bling): To ensure effective communication with residents or residents who are deaf or hard of hearing, the agency provide access to interpreters who can interpret effectively, accurately, and impartially both receptively and expressively, using any necessary specialized vocabulary. Interpreter Services Agreement (Dated 4/30/2024). The interpreter services are for Spanish speaking only. Policy 13.8.1 (Protection from Sexual Abuse and Assault) states that "Facilities shall take reasonable steps to ensure meaningful access to all aspects of the SAYS efforts to prevent, detect, and respond to sexual abuse and sexual harassment to juveniles who are limited English proficient, including steps to provide interpreters who can interpret, and impartially, both receptively and expressively, using any necessary specialized vocabulary" (p. 4). Interviews: Residents (with disabilities or who are limited English proficient) – During the onsite portion of the audit, there were no residents identified as having a disability or limited English proficient. Corrective Actions: N/A. There are no corrective actions. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.316 (c). The agency shall not rely 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.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

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

Policy 13.1.8 (Protection from Sexual Abuse and Assault) states that "Facilities shall not rely on juvenile interpreters, juvenile readers, or other types of juvenile assistants except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the juvenile's safety, the performance of first• responder duties, or the investigation of the juvenile's allegations" (p. 4).

Interviews:

Random Sample of Staff: All of the staff members interviewed confirmed that they had never encountered a situation in which a resident in custody was permitted to act as an interpreter to report allegations of sexual abuse or sexual harassment. One staff member interviewed stated it was unknown if residents were allowed to be interpreters.

Residents (with disabilities or who are limited English proficient) – There were no identified resident with disabilities or limited English proficient.

Corrective Actions:

N/A. There are no corrective actions.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision.

Overall Findings:

The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.317	Hiring and promotion decisions
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Employment Questionnaire b. Policy 3.1 (Recruitment and Selection) c. Policy 3.2 (Background Checks) d. List of all staff e. New Hire File: i. Criminal Background Check (20) ii. Reference Check iii. Pre-employment questionnaire. f. Five-year background check/promotions - 6 2. Interviews: a. HR administrator 3. Corrective Action: a. Prior Institutional Employment Completed b. Prior Institutional Employment Form Findings (By Provision): 115.317 (a). The agency shall not hire or promote anyone who may have contact with residents, and shall not enlist the services of any contractor who may have contact with residents, who (1) Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997); (2) Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or (3) Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a)(2) of this section. Compliance Determination: The facility has demonstrated compliance with this provision of the standard

	because: As reported in the PAQ, the facility 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. Policy 3.1 (Recruitment and Selection) states that "SAYS shall not hire or promote anyone, or enlist the services of any contractor, 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; or has been civilly or administratively adjudicated to have engaged in such activity" (p. 1). New Hire Criminal Background Checks (20) provides documentation, and the agency has a consistent practice of completing background checks. Files of persons hired or promoted in the past 12 months to determine whether proper criminal record background checks have been conducted and questions regarding past conduct were asked and answered. Prior conduct is asked on the employee application. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.316 (b). The agency shall 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the facility, 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.

	Policy 3.1 (Recruitment and Selection) states that "SAYS shall consider any incidents of sexual harassment, 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 juveniles. Before hiring new employees who may have contact with juveniles, SAYS shall: (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; 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" (p.1). Interviews: Administrative (Human Resources) – The interviewed human resources staff reported that the facility considers prior 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. However, it was further reported that the agency does not contact prior institutional employers to determine if there were prior incidents of sexual harassment. Corrective Actions: Corrective Action Plan (Prior Institutional Employment): The facility shall provide documentation of its process to conduct references on staff that have prior institutional employment. Correction Action Taken: The facility provided documentation of a form created used to conduct reference checks on staff who have prior institutional employment. During the corrective action phase, the facility did not have a new hire staff at the audited location with prior institutional employment; however, the facility provided documentation of another site location where the prior institutional reference check was conducted. Therefore, showing how the agency implemented the requirements of the provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.317 (c). 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 Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

The facility indicated in their responses to the Pre-Audit Questionnaire (PAQ) that the facility 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 the past 12 months, the number of persons hired who may have contact with residents who have had criminal background record checks: 51.

Policy 3.1 (Recruitment and Selection) states that "SAYS shall also perform a criminal background records check, and consult applicable child abuse registries, before enlisting the services of any contractor who may have contact with juveniles. SAYS shall conduct criminal background records checks at least every five years on current employees and contractors who may have contact with juveniles" (p. 1). New Hire Criminal Background Checks (20)

New Hire Criminal Background Checks (20) provides documentation, and the agency has a consistent practice of completing background checks.

Interviews:

Administrative (Human Resources)- The interviewed human resources staff reported that the facility performs criminal record background checks or considers pertinent civil or administrative adjudications for all newly hired employees who may have contact with residents and all employees, who may have contact with residents, who are being considered for promotions. Similar checks are also conducted on contractors who may have contact with residents. In addition to the background check, a child abuse registry check with the State of Alabama is conducted on new employees and contractors who may have contact with residents.

Corrective Actions:

Corrective Action Plan: the agency shall develop a plan that conducts a reference check on prior institutional employers to determine if a staff or contractor may have prior incidents of sexual harassment. This plan should be incorporated during the pre-employment process and when promoting an internal candidate. The agency shall provide an auditor with a copy of the plan and documentation showing it was implemented on new hires and/or promotions. Due: 12/1/2024.

Corrective Action Taken: The facility developed a form to conduct reference checks on potential employees and prior institutions in which they employer worked. During the corrective action phase, the facility did not have a new hire staff at the audited location with prior institutional employment; however, the facility provided documentation of another site location where the prior institutional reference check was conducted. Therefore, showing how the agency implemented the requirements of the provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.317 (d): The agency shall also perform a criminal background records check, and consult applicable child abuse registries, before enlisting the services of any contractor who may have contact with residents.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

The facility indicated in their response to the PAQ that agency policies require 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. In the past 12 months, the number of contracts for services where criminal background record checks were conducted on all staff covered in the contract who might have contact with residents: 0.

Policy 3.2 (Background Checks) states that "Before hiring new employees, who may have contact with juveniles the agency shall:

· Perform a criminal background records check;

· Consults any Child Abuse Registry maintained by the State or locality in which the employee would work; and

· Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiate allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse (p. 1).

Interviews

Administrative (Human Resources)- The interviewed human resources staff reported that the facility performs criminal record background checks or considers pertinent civil or administrative adjudications for all newly hired employees who may have contact with residents and all employees, who may have contact with residents, who are being considered for promotions. Similar checks are also conducted on contractors who may have contact with residents.

Corrective actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.317 (e). The agency shall 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.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

The facility indicated in their responses to the Pre-Audit Questionnaire (PAQ) that the facility 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.

Policy 3.2 (Background Checks) states that "The agency shall either conduct criminal background records check at least every five years of current employees and volunteers or who may have contacts with juveniles or have in place a system for otherwise capturing such information for current employees" (p. 1).

As reported by the facility, the site opened in 2022 and has not had any staff employed for five years.

Interviews:

Administrative (Human Resources)-The human resources staff interviewed reported that the system the facility presently has in place to conduct criminal record background checks of current employees and contractors who may have contact with residents is the Nationwide Criminal Watchdog. This is done on promotions, re-hires, and every five years.

Corrective actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115. 317 (f). The agency shall also 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 and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.

Compliance Determinations:

The facility has demonstrated compliance with this provision of the standard because:

The agency should also 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 and in any interviews or written self-evaluations conducted as part of reviews of current employees. The agency shall also impose upon employees a continuing affirmative duty to disclose any such misconduct.

Previous misconduct questions are asked on the employee application.

Interviews:

Administrative (Human Resources) – The interviewed human resources staff reported that the facility asks all applicants and contractors who may have contact with residents about previous misconduct described in section (a)* in written applications for hiring or promotions, and in any interviews or written self--
-evaluations conducted as part of reviews of current employees. Applicants and employes sign a form indicating their responsibility to disclose.

Corrective Actions:

N/A. There are no corrective actions.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.317 (g). Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

According to the PAQ, the agency's policy states that material omission regarding misconduct, or the provision of materially false information, shall be grounds for termination.

Policy 3.1 (Recruitment and Selection) states that "SAYS mandates that all employees have a continuing affirmative duty to report any such sexual misconduct. Material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination" (p. 2).

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.317 (h). Unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or sexual harassment involving a former

115.318	employee upon receiving a request from an institutional employer for whom such employee has applied to work. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Unless prohibited by law, the agency shall 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. Interviews: Administrative (Human Resources) – The interviewed human resources staff reported that when a former employee applies for work at another institution, upon request from that institution, the facility provides information on substantiated allegations of sexual abuse or sexual harassment involving the former employee, unless prohibited by law. The request is verified via telephone. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard. Upon completing the final review, it was found that the requested documentation, as per the PREA standard provisions, needs corrective action to address contacting prior institutional employers and employee misconduct. The interim report finds the standard non-compliant. The corrective actions were completed and follow up reviewed confirmed that the facility implemented and documented a practice of contacting prior institutional employers. With these measures in place, the initial audit findings are resolved, and the facility is compliant with the provisions of the standard.

115.318	**Upgrades to facilities and technologies**
	Auditor Overall Determination: Meets Standard

	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Facility Design/Set Up 2. Interviews: a. Agency head b. Director Findings (By Provision): 115.317 (a). When designing or acquiring any new facility and in planning any substantial expansion or modification of existing facilities, the agency shall consider the effect of the design, acquisition, expansion, or modification upon the agency's ability to protect residents from sexual abuse. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The facility indicated in their responses to the Pre-Audit Questionnaire (PAQ) that the facility has not acquired a new facility or made substantial expansions or modifications to the existing facility since the last PREA audit. However, upon review the location of this site was recently opened and this serves as their first PREA audit. Interviews Agency Head – The interviewed agency head reported that all planning for facility expansion and/or modification takes into consideration the design and video monitoring/surveillance to protect residents from sexual abuse by working with professionals who have an understanding/experience in working with PREA/DYS standards regarding juveniles. Since we work closely with those standards, we utilize all oversight with this in mind. Director– All of the above are considered in the design of the facility; however, there is no plan for an extension. The site is newly redesigned for the program. The instillation of cameras and the setup of the room was designed for the program. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision.

	115.316 (b). When installing or updating a video monitoring system, electronic surveillance system, or other monitoring technology, the agency shall consider how such technology may enhance the agency's ability to protect residents from sexual abuse. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The facility reported in the PAQ that they have not installed or updated its video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit. Interviews: Agency Head: The interviewed agency head reported that regular monitoring of the grievance system in addition to pulling random videos occurs by the PREA coordinator. Director: There are no upgrades however the cameras are monitored offsite at the Administrative Offices. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.321	**Evidence protocol and forensic medical examinations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Documents:

	1. Documents: a. Policy 13.8.1 (Protection from Sexual Abuse and Assault) b. Pre-Audit Questionnaire c. MOU-Barber County Sheriff’s Office/Louisville Police Department (May 16, 2024) d. Uniform Evidence Protocol Checklist e. MOU: Southeast Alabama Child Advocacy Center f. Child Advocacy Center SANE Program Overview 2. Interviews: a. Random sample of staff -10 b. Child Advocacy Center c. PREA Compliance Manager 3. Corrective Action: a. Staff Refresher Training (17) Findings (By Provision): 115.321 (a). As reported in the PAQ, the agency/facility is responsible for conducting administrative sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). The agency/facility is responsible for conducting criminal sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). It was further reported that when conducting a sexual abuse investigation, the agency investigators follow a uniform evidence protocol. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency/facility is not responsible for conducting administrative sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). The agency/facility is not responsible for conducting criminal sexual abuse investigations (including resident-on-resident sexual abuse or staff sexual misconduct). It was further reported that when conducting a sexual abuse investigation, the outside investigators follow a uniform evidence protocol. The agency provided an MOU with Barbour County Sheriff’s Office stating that the Sheriff’s Office will conduct investigations on allegations of sexual abuse and sexual harassment.

Uniform Evidence Protocol Checklist: the site provides a protocol addressing how to manage and document evidence.

Interviews

Random Sample of Staff: During the onsite audit, the random staff were asked, “Do you know and understand the agency’s protocol for obtaining usable physical evidence if an individual in custody alleges sexual abuse?” Most of the staff interviewed were aware of the agency’s protocols. Those that did not the protocol stated that they would protect physical evidence, which included separating the residents in custody, securing the area, not allowing the victim to shower or brush teeth, immediately seeking medical attention and contacting supervisor. All staff members reported varies responses regarding who is responsible for conducting sexual abuse investigations it includes:

- Supervisors
- Director
- PREA Coordinator
- DYS/Law Enforcement

Corrective Actions:

- Staff Training: While staff generally have an understanding of the protocol for obtaining evidence. There was a small selection of interviewed staff who did not have a clear understanding of the process. The auditor is recommending that staff are retrained on the process. The facility should provide documentation that staff were retrained.

Corrective Action Implemented: the facility provided documentation that staff received refresher training to include Evidence Protocol. The training occurred on 10/1/2024. No further action is needed.

115.321(b). The protocol shall be developmentally appropriate for youth and, as appropriate, shall be 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.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported by the PAQ, the protocol is developmentally appropriate for youth. The protocol was adapted from or otherwise based on the most recent edition of the DOJ’s Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents,” or similarly

	comprehensive and authoritative protocols developed after 2011. Uniform Evidence Protocol Checklist: the site provided a protocol addressing how to manage and document evidence. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.321 (c). The agency shall offer all residents who experienced sexual abuse access to forensic medical examinations whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The facility indicated in their responses to the Pre-Audit Questionnaire that the facility 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 facility responded that forensic medical examinations are offered without financial cost to the victim. It was further reported that when SANEs or SAFEs are not available, they offer a qualified medical practitioner to perform forensic medical examinations. The number of forensic medical exams conducted during the past 12 months: 0. The number of exams performed by SANEs/SAFEs during the past 12 months: 0. The number of exams performed by a qualified medical practitioner during the past 12 months: 0. Policy. 13.8.1 (Protection from Sexual Abuse and Assault) states that “The facility shall offer all juveniles who experience sexual abuse access to forensic medical examinations without financial cost. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The facility shall document its efforts to provide SAFEs or SANEs” (p. 9). MOU: Southeast Alabama Child Advocacy Center states that the Child Advocacy Center will accompany a youth during the forensic examination process. Child Advocacy Center SANE Program Overview: The overview states that the Southeast Alabama Child Advocacy Center serves Dale, Geneva, Henry, and Houston Counties. The center provides 24/7/365 SANE services for children birth to

18 years of age.

Interviews

Child Advocacy Center- The auditor spoke to leadership at the advocacy center in reference to the Child Advocacy Center- Email correspondence with the victim advocacy center, confirmed the victim advocacy center identified by the agency contract can provide victim advocacy, emotional supportive, and forensic services for residents at the program. The program further indicated that they have not had to render services for residents at the program in the last 12 months.

Corrective Actions:

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.321 (d). The agency shall attempt 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 agency shall make available to provide these services a qualified staff member from a community-based organization, or a qualified agency staff member. Agencies shall document efforts to secure services from rape crisis centers. For the purpose of this standard, a rape crisis center refers to an entity that provides intervention and related assistance, such as the services specified in 42 U.S.C. 14043g(b)(2)(C), to victims of sexual assault of all ages. The agency may utilize a rape crisis center that is part of a governmental unit as long as the center is not part of the criminal justice system (such as a law enforcement agency) and offers a comparable level of confidentiality as a nongovernmental entity that provides similar victim services.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

The facility indicated in their responses to the Pre-Audit Questionnaire that it has made 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 facility makes available to provide these services a qualified staff member from a community-based organization, or a qualified facility staff member.

MOU: Southeast Alabama Child Advocacy Center states that the Child Advocacy Center will accompany a youth during the forensic examination process. Additionally, the MOU provides an overview of the victim advocacy and emotional support services that the child advocacy center will provide to any referred victim.

Interviews:

PREA Compliance Manager – The agency would make or attempt to give a resident access to a victim advocate by taking in person or assisting them with a phone call. The agency uses the state approved rape crisis centers.

	Residents who Reported a Sexual Abuse – There were no residents onsite that reported sexual abuse. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.321 (e). As requested by the victim, the victim advocate, qualified agency staff member, or qualified community-based organization staff member shall accompany and support the victim through the forensic medical examination process and investigatory interviews and shall provide emotional support, crisis intervention, information, and referrals. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The facility 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. MOU: Southeast Alabama Child Advocacy Center states that the Child Advocacy Center will accompany a youth during the forensic examination process. Additionally, the MOU provides an overview of the victim advocacy and emotional support services that the child advocacy center will provide to any referred victim. Interviews: PREA Compliance Manager: The interviewed staff reported that if requested the facility would coordinator services with the rape crisis center. Residents who Reported a Sexual Abuse – There were no residents onsite that reported sexual abuse. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.321 (f). To the extent the agency itself is not responsible for investigating allegations of sexual abuse, the agency shall request that the investigating agency follow the requirements of paragraphs (a) through (e) of this section.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

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

The agency provided an MOU with Barbour County Sheriff's Office stating that the Sheriff's Office will conduct investigations on allegations of sexual abuse and sexual harassment.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

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

115.321 (h). For the purposes of this standard, a qualified agency staff member or a qualified community-based staff member shall be an individual who has been screened for appropriateness to serve in this role and has received education concerning sexual assault and forensic examination issues in general.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

The facility will utilize licensed clinical staff to assist with victim advocacy and emotional support if needed.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

Overall Findings:

The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.322	Policies to ensure referrals of allegations for investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: 1.29.1 (Referrals of Sexual Abuse/Assault/Harassment Allegations for Investigations) c. Policy: 1.29 Special Investigation Unit d. Documentation of Reports of Sexual Abuse or Sexual Harassment (5) e. Website: www.saysdothan.com/prea 2. Interviews: a. Agency head b. Investigative staff - 1 Findings (By Provision): 115.322 (a): The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. Compliance Determinations: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency ensures that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment. In the past 12 months, the number of allegations of sexual abuse and sexual harassment that were received: 5. In the past 12 months, the number of allegations resulting in an administrative investigation: 5. In the past 12 months, the number of allegations referred to for criminal investigation: 0. Policy: 1.29.1 (Referrals of Sexual Abuse/Assault/Harassment Allegations for Investigations), provides a process for the agency to conduct its own investigations into allegations of sexual abuse and sexual harassment and when investigations are

referred to an outside investigator.

Documentation of Reports of Sexual Abuse or Sexual Harassment (5). Upon review it was determined that all allegations were sexual harassment in nature.

Interviews

Agency Head: The interviewed agency head stated that SAYS has three PREA-trained investigators and a PREA Coordinator who manages investigations, not requiring immediate 3rd party participation. If necessary, MOUs are in place and included for evaluation by a SANE/SART nurse and a police investigation, if this is required. The policies and procedures are outlined in each facility's PREA Investigation manual. All allegations of sexual abuse or harassment are conducted exactly as indicated in the PREA Investigation Manual and the PREA standards as part of SAYS policy and procedures.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.322 (b). The agency shall have in place a policy to ensure that allegations of sexual abuse and/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. The agency shall publish such policy on its website or, if it does not have one, make the policy available through other means. The agency shall document all such referrals.

Compliance Determinations:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the facility 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. In addition, the facility reported in the PAQ that the agency's policy regarding the referral of allegations of sexual abuse or sexual harassment for a criminal investigation is not published on the agency website or made publicly available via other means.

Policy 1.29 (Special Investigation Unit) provides an overview of the administrative investigation process. The process addresses who will conduct the investigations and how the investigations will be conducted.

Interviews

Investigative Staff: The interviewed staff reported that the policy requires that allegations of sexual abuse or sexual harassment are investigated by agency investigators, DYS, or local law enforcement.

	Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.322 (c). If a separate entity is responsible for conducting criminal investigations, such publication shall describe the responsibilities of both the agency and the investigating entity. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Website: PREA — Southeast Alabama Youth Services, Inc. (saysdothan.com) provides information on how to make a report and who reports will be referred. The site also provides that a person could directly report to the local police department. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 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. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.331	**Employee training**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents:

	a. Pre-Audit Questionnaire (PAQ) b. Policy 4.3.1 Sexual Abuse/Assault/Harassment Training c. Policy 4.3.1 Sexual Abuse/Assault/Harassment Training further reiterates the agency expectations of staff training. d. Training Documents: i. Key Terms and Definitions ii. Code of Alabama Mandatory Reporting iii. Red Flas of Sexual Assault iv. First Responder Checklist v. First Responder Guidelines for Sexual Assault vi. Unit 3-2 Response and Reporting vii. Unit 3-1 Prevention and Detection viii. Unit 2 Rights to be Free ix. Unit 1 PREA Overview x. Unit 4 Professional Boundaries xi. Unit 5 Effective Professional Communication xii. Mandated Reporters Training e. Mandated Reporting Training Certificates (20) f. Mandated Reporter Trainer g. Staff Confirmation Receipt of PREA/Acknowledgement (20) h. Training Sign in Sheets i. 1/18/2024 (4 completed) ii. 1/23/2024 (3 completed) iii. 4/16/2024 (11 completed) iv. 4/18/2024 (4 competed) i. Refresher Training (8/20/2024) (14) 2. Interviews: a. Random sample of staff – 10

	3. Corrective Action: a. Staff Refresher Training (10/1/2024) Findings (By Provision): 115.331 (a). The agency shall train all employees who may have contact with residents on:(1) Its zero-tolerance policy for sexual abuse and sexual harassment;(2) How to fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures;(3) Residents' right to be free from sexual abuse and sexual harassment;(4) The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment;(5) The dynamics of sexual abuse and sexual harassment in juvenile facilities;(6) The common reactions of juvenile victims of sexual abuse and sexual harassment;(7) How to detect and respond to signs of threatened and actual sexual abuse and how to distinguish between consensual sexual contact and sexual abuse between residents;(8) How to avoid inappropriate relationships with residents;(9) How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents; and(10) How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities;(11) Relevant laws regarding the applicable age of consent. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency trains all employees who may have contact with residents in the following matters: o The agency’s zero-tolerance policy for sexual abuse and sexual harassment; o How staff fulfill their responsibilities under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures; o Residents right to be free from sexual abuse and sexual harassment; o The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment; o The dynamics of sexual abuse and sexual harassment in resident facilities; o The common reactions of sexual abuse and sexual harassment victims; o How to detect and respond to signs of threatened and actual sexual abuse; o How to avoid inappropriate relationships with residents; o How to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents;

	o How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities.; and o Relevant laws regarding the applicable age of consent. Policy 4.3.1 Sexual Abuse/Assault/Harassment Training further reiterates the agency expectations of staff training. · Training Documents: o Key Terms and Definitions o Code of Alabama Mandatory Reporting o Red Flas of Sexual Assault o First Responder Checklist o First Responder Guidelines for Sexual Assault o Unit 3-2 Response and Reporting o Unit 3-1 Prevention and Detection o Unit 2 Rights to be Free o Unit 1 PREA Overview o Unit 4 Professional Boundaries o Unit 5 Effective Professional Communication o Mandated Reporters Training The Mandated Reporters Training is online and provided by the State of Alabama Department of Human Resources. Mandated Reporting Training Certificates (20) Staff Confirmation Receipt of PREA Training (13) · Training Sign in Sheets o 1/18/2024 (4 completed) o 1/23/2024 (3 completed) o 4/16/2024 (11 completed) o 4/18/2024 (4 competed) Interviews Random Sample of Staff – All of the interviewed random sample of staff reported

	that they have been trained on the agencies zero tolerance policy for sexual abuse or sexual harassment. The staff reported that the training included the following elements: 1) During employee orientation and annually, staff shall receive the following PREA training: a. The facility's zero tolerance for all forms of sexual abuse and sexual harassment. b. How to fulfill their responsibilities in regard to prevention, detection, reporting, and response. c. The resident's right to be free from of sexual abuse and sexual harassment. d. The resident's and staff member's right to be free from retaliation for reporting sexual abuse and sexual harassment e. The dynamics of sexual abuse and sexual harassment in residential settings, including determining which residents are most vulnerable. f. The common reactions of sexual assault or sexual abuse victims g. How to avoid inappropriate relationships with residents h. How to communicate effectively and professionally with all residents and i. How to comply with relevant laws related to the mandatory reporting of sexual abuse to authorities. When probed the staff could elaborate on the signs and what to look out for if someone is being victimized, and some of the dynamics of sexual abuse and sexual harassment in confinement settings. The only area where staff was unsure is age of consent as they reported there is no consent at the program. Corrective Actions: · When conducting interviews interviewed staff were not as clear on the age of consent portion of the training. The facility should provide additional training for staff. Corrective Action Implemented: Additional training on age of consent was provided to staff on 10/1/2024; documented on a training roster. No further action is needed. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.331 (b). Such training shall be tailored to the unique needs and attributes of residents of juvenile facilities and to the gender of the residents at the employee's facility. The employee shall receive additional training if the employee is reassigned from a facility that houses only male residents to a facility that houses only female

residents, or vice versa.

Compliance Determination:

The facility reported in the PAQ that training is tailored to meet the unique needs and attributes and gender of the residents at the facility. Employees who are reassigned from facilities housing the opposite gender are not given additional training.

Training Documents (Unit 5 Effective-Professional Communication)

Policy 4.3.1 Sexual Abuse/Assault/Harassment Training further reiterates the agency expectations of staff training.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.331 (C). All current employees who have not received such training shall be trained within one year of the effective date of the PREA standards, and the agency shall 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. In years in which an employee does not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, between trainings the agency provides employees who may have contact with residents with refresher information about current policies regarding sexual abuse and harassment. The frequency of the training is annually.

Policy 4.3.1 Sexual Abuse/Assault/Harassment Training further reiterates the agency expectations of staff training.

Refresher Training Records (Dated 8/20/224): Refresher training was provided to existing and some of the new hire staff. Fourteen acknowledgment signatures were documented on the training roster.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

	115.331 (d). The agency shall document, through employee signature or electronic verification, that employees understand the training they have received. Compliance Determinations: The facility has demonstrated compliance with this provision of the standard because: The agency shall document, through employee signature or electronic verification, that employees understand the training they have received. All new hires sign two different documents during orientation. The agency/facility trains all employees who may have contact with residents on PREA training topics. Employees receive this training prior to having contact with residents. The agency/facility provides PREA training as a part of pre-service/ orientation. Training is also reinforced and enhanced by on-the-job training, shift briefings, staff meetings and management meetings where experienced and knowledgeable staff members work with new hires to educate them further about PREA practices. The PREA training is documented through rosters (staff signatures or electronic verification), meeting minutes, shift briefing notes. Training Acknowledgement (20). Twenty training acknowledgment documents were reviewed: whereas documentation of staff written acknowledgement of receipt of training. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.332	**Volunteer and contractor training**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Documentation:

	1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy 4.3.1 Sexual Abuse/Assault/Harassment Training c. Training Records (1) 2. Interviews: a. Volunteers or contractors who have contact with residents (1) 115.332 (a). The agency shall ensure 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, all volunteers and contractors who have contact with residents have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response. The number of volunteers and individual contractors who have contact with residents who have been trained in agency policies and procedures regarding sexual abuse and sexual harassment prevention, detection, and response: 1. Policy 4.3.1 Sexual Abuse/Assault/Harassment Training further reiterates the agency expectations of training volunteers and contractors. The policy explicitly states the expectations of volunteers being trained, understanding policy, and maintains documentation of receipt of training (p. 2) Training Record (1). As reported by the PREA Coordinator the Director provides the packet for the volunteer to read and then goes over the information with them. Interviews: Volunteer(s) or Contractor(s) who have Contact with Residents: The interviewed teacher reported that they were recently contracted to provide services at the facility. It was reported that they have been trained in PREA. The training included items such as preventing sexual abuse and rape and how to make a report. The contracted staff stated that they received the training via video and staff went over the rules. Corrective Actions: Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

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

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

The facility reported in the PAQ, that all volunteers and contractors who have contact with residents have been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

Volunteer Training Curriculum: The volunteers watch a video go over written policy with the staff.

Training Record (1). Provides documentation of a contracted employee completion of PREA training.

Interviews:

Volunteer(s) or Contractor(s) who have Contact with Residents: The interviewed teacher reported that they were recently contracted to provide services at the facility. It was reported that they have been trained in PREA. The training included items such as preventing sexual abuse and rape and how to make a report. The contracted staff stated that they received the training via video and staff went over the rules.

Corrective Actions:

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.332 (c). The agency shall maintain documentation confirming that volunteers and contractors understand the training they have received.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the agency maintains documentation confirming that the volunteers and contractors understand the training they have received.

The agency/facility ensure that volunteers and contractors who have contact with residents are trained in their responsibilities regarding sexual abuse and sexual harassment prevention, detection, response policies and procedures at the agency/facility in which they are working.

The agency/facility also ensures that everyone in the facility, including volunteers and contractors, understand the agency's zero-tolerance policy toward sexual abuse and sexual harassment, that the agency prohibits them from engaging in sexual relations with residents and that sexual abuse and sexual harassment is always reported.

Training Records/Signed Acknowledgement: 1

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

Overall Findings:

The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.333 Resident education

Auditor Overall Determination: Meets Standard

Auditor Discussion

The following evidence was analyzed in making compliance determination:

1. Documents:

a. Pre-Audit Questionnaire (PAQ)

b. Policy 5.1 (Juvenile Orientation Admission Record Requirements

c. PREA Pamphlet Sign Off (30)

d. PREA Posters English/Spanish

e. Resident PREA Brochure (English/Spanish)

f. Resident Handbook (English/Spanish)

2. Interviews:

a. Intake staff - 1

b. Random sample of residents - 10

3. Corrective Action

a. PREA Posters-completed

b. Resident Education (10)

c. Resident Census

Findings (By Provision):

115.333 (a). During the intake process, residents shall receive information explaining, in an age appropriate fashion, the agency's zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, residents receive information at time of intake about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or sexual harassment. The number of residents admitted in past 12 months who were given this information at intake: 52. It was further reported that the information is provided in an age-appropriate fashion.

Policy 5.1 Juvenile Orientation states that “During the intake process, juveniles shall receive information explaining, in an age• , the SAYS zero tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. Juveniles shall be given at intake a copy of SAYS Form 115.333.a Juvenile PREA Handbook. This pamphlet shall be read by staff to all juveniles in groups or individually. Juveniles shall be explained their right to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents. The SAYS Form 115.333.1 SAYS Youth Safety Guide shall be read to juveniles in groups or individually and copies shall be given to each juvenile during the intake process. Juvenile PREA training video shall also be shown to juveniles once a month throughout their stay (p.1).

PREA Pamphlet Sign Off (30). The Pamphlet provides information on what a sexual assault is, how to avoid Rape, the allegation will be investigated, and what to do if you are sexually assaulted.

Resident Handbook brochure (English/Spanish): the resident handbook/brochure provides information to residents on information about sexual abuse and sexual harassment, an allegation will be investigated, how to avoid rape, what to do if you are sexually assaulted, how to make a report.

No Means No Poster (English/Spanish): the poster provides information on how to

	make a report, who to report to and access to victim advocacy and emotional support services. Additionally, residents watch a PREA video designed by the PREA Resource Center (PREA Juvenile Comprehensive by PREA Resource Center) Resident Roster in the last 12 months provided a comprehensive list of residents housed at the facility in the last 12 months. The auditor was able to review the list to randomly select files to review. PREA Confirmation Signage (30) was reviewed documenting residents' receipt of PREA Education at Intake. Site Review · During the site review the auditor verified that the intake process is completed by multiple entities. Once the resident is brought to the nursing area, the nursing staff will go over the PREA assessment form and additional medical documents. The Mental Health staff will then review what was reported by the resident with the resident. In addition, the case manager and director in conjunction with nursing staff will play the PREA video and go over the facility rules with the resident. The facility was absent a nurse and a case manager therefore the director who is also a Nurse was filling in for the process. The Director, along with the mental health staff, was able to conduct a mock of the process. · Informal conversation with the residents verified the process that is taken upon entry into the facility. Additionally, the auditor watched the PREA video given to the residents while conducting the onsite portion of the audit. The video provided to the residents is a video uploaded as a resource for the PREA Resource Center. · The facility has PREA documentation readily available in English, Spanish and for individuals who have cognitive disabilities. · Mental Health staff reported that they follow up with all residents regardless of their cognitive or functional level as the residents may later report something and they have opportunity to build rapport. Although there were no new intakes during the audit, a mock intake was conducted by a mental health staff member, revealing the following: An overview of how they introduce themselves, discuss what brought the resident to the site, their average length of stay and several authorizations. Written materials, including the PREA Client Handbook and the Facility Rules Handbook, are provided at an appropriate reading level and are accessible to all residents, including those with limited English proficiency (LEP). These handbooks are available in both English and Spanish. The facility offers interpreter services when needed, including for Deaf and non-English speaking residents. The intake staff would coordinate with the facility director to arrange these services if required. Furthermore, it was reported that if they were made aware of a disability that would find out what the disability was and

	determine what services were needed. During the mock intake, the staff demonstrated how they review the PREA Client Handbook and Facility Rules Handbook with residents, asking follow-up questions to ensure comprehension. They also request residents to provide examples to confirm their understanding. The intake staff also showed the auditor how they present the PREA video to residents as part of the orientation process. The mental health staff are also responsible for educating residents on the facility's rules regarding sexual abuse and harassment during intake. It should also be noted that during intake the residents receive information about mandatory reporting requirements and the limitations to confidentiality. The staff demonstrated that once they go over the documents the residents watch the PREA video and sign acknowledging receipt of information. Informal Conversations: Informal conversations with residents confirmed that the intake and mental health staff reviewed the PREA-related information and showed them a video during the intake process. INTERPRETATION SERVICES · While the facility did not have any residents who were limited English Speaking, the auditor was able to assess securing interpretation services on-demand. o The auditor contacted the language line and spoke to the staff on the process of accessing on demand languages. The staff walked the auditor through the process so the site would not be charged for the use of services. · The residents at the facility do not have access to a phone at any given time, therefore accessing such services would be limited to staff requests for services. · The interpreter services are available 24/7 with staff assistance to access the line. · As described by the Clinician, in coordination with the Director the language line services would be accessed and the use of the interpreter would occur in a closed-door office. Interviews Intake Staff: The interviewed staff reported that during admission to the facility all youth are provided information regarding agency’s zero tolerance policy for sexual abuse or sexual harassment. During the intake process, the residents watch a PREA video, PREA Acknowledgement form as well as given a handout regarding prevention and reporting sexual abuse or sexual harassment. We will ask questions of the residents to make sure they understand the information that was given to them. The nurse and mental health staff are also a part of the intake process. Residents(s) in custody Interview Questionnaire: Ten residents in custody were

interviewed. All of the interviewed residents reported that upon arrival they were given information about the facilities rules against sexual abuse and harassment. The residents discussed various methods in which the received the information, to include staff telling them, PREA video, and a handbook.

Corrective Actions:

· Resident Education: Upon review of the information provided to residents at intake the auditor recommended that the site also provide the mailing address to the outside reporting entity (Ruth House).

Corrective Action Implemented: The brochure was updated. No further action is needed.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.333 (b). Within 10 days of intake, the agency shall provide comprehensive age-appropriate education to residents either in person or through video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, 150 residents that were admitted in the facility 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. It should also be noted that the facility reported that education is provided by giving the residents a brochure and the education classes have been suspended due to COVID.

Resident Handbook/brochure (English/Spanish): the resident handbook/brochure provides information to residents on information about sexual abuse and sexual harassment, an allegation will be investigated, how to avoid rape, what to do if you are sexually assaulted, how to make a report.

No Means No Poster (English/Spanish): the poster provides information on how to make a report, who to report to and access to victim advocacy and emotional support services.

Resident Roster in the last 12 months provided a comprehensive list of residents housed at the facility in the last 12 months. The auditor was able to review the list to randomly select files to review.

PREA Confirmation Signage (30) was reviewed documenting residents’ receipt of

	PREA Education at Intake. Site Review Although no new intakes occurred during the audit, the director conducted a mock intake, revealing the following: · Written Materials: The PREA Client Handbook and Facility Rules Handbook are provided at an appropriate reading level and are accessible to all residents, including those with limited English proficiency (LEP). These handbooks are available in both English and Spanish. · Interpreter Services: The facility offers interpreter services when needed, including for Deaf and non-English speaking residents. Intake staff coordinate with the facility director to arrange these services as required. · Mock Intake Demonstration: During the mock intake, staff demonstrated how they review the PREA Client Handbook and Facility Rules Handbook with residents. They ask follow-up questions and request residents to provide examples to ensure comprehension. · PREA Video Presentation: The intake staff also showed the auditor how they present the PREA video to residents as part of their orientation. · PREA Client Handbook Contents: The auditor confirmed that the PREA Client Handbook includes detailed information on the following topics: o Overview of PREA o Facility Rules o Allegations will be investigated o How to avoid rape o What to do if you are sexually assaulted o How to make a report Interviews Intake Staff: The interviewed staff reported that during admission to the facility all youth are provided information regarding agency's zero tolerance policy for sexual abuse or sexual harassment. During the intake process, the residents watch a PREA video, get a handout/brochure, and we verbally go over the information with them. Intake typically occurs on the same day of arrival at the facility. Residents(s) in custody Interview Questionnaire: Ten residents in custody were interviewed. All of the residents reported that upon arrival at the facility they were told about their right not to be sexually abused or sexually harassed, how to report sexual abuse or sexual harassment, and their right not to be punished for reporting

	sexual abuse or sexual harassment. The information was typically provided on the first day by staff and the resident was able to describe receiving a handbook and watching the PREA video. Corrective Actions: · Resident Acknowledgement: Upon review of the resident acknowledgment of receipt of PREA Education, it was determined that nine residents did not receive education material in a timely manner. The facility shall provide a list of all new residents placed at the facility during the months of September and October 2024. The facility shall upload all documentation of acknowledgment of PREA education for all new intakes in the month of September and October 2024. · Corrective Action Implemented: The facility provided documentation of new resident intakes (10) for the requested time period. Upon reviewing documentation, the residents received timely notification and education on PREA. The requested documentation was provided no further action needed. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.333 (c). Current residents who have not received such education shall be educated within one year of the effective date of the PREA standards and shall 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, all residents received PREA related education within 10 days of being placed at the facility. Additionally, residents transferred from another facility will receive PREA education upon intake and during orientation. It was further reported that the residents receive PREA education within the date of admission. Policy 5.1 Juvenile Orientation states that “. Current juveniles who have not received such orientation shall be educated within one year of the effective date (August 20, 2013) of the PREA standards and shall receive PREA education upon transfer to a different facility to the extent that the policies and procedures of the juvenile's new facility differ from those of the previous facility and documented using SAYS Form 115.333 Juvenile Confirmation Receipt of PREA. SAYS Form 115.333 will be issued and signed upon completion of juvenile orientation and should be completed within 10 days of intake (p.2). All residents housed in the facility whether transfer or new intake received PREA education. All residents placed at the site were placed in the last year. The Auditor identified that nine did not receive information in a timely manner.

Interviews

Intake Staff: The interviewed staff reported that during admission to the facility all youth are provided information regarding agency's zero tolerance policy for sexual abuse or sexual harassment. During the intake process, the residents watch a PREA video, PREA Acknowledgement form as well as given a handout regarding prevention and reporting sexual abuse or sexual harassment. We will ask questions of the residents to make sure they understand the information that was given to them. The nurse and mental health staff are also a part of the intake process.

Corrective Actions:

· Resident Acknowledgement: Upon review of the resident acknowledgment of receipt of PREA Education, it was determined that nine residents did not receive education material in a timely manner. The facility shall provide a list of all new residents placed at the facility during the months of September and October 2024. The facility shall upload all documentation of acknowledgment of PREA education for all new intakes in the month of September and October 2024.

· Corrective Action Implemented: The facility provided documentation of new resident intakes (10) for the requested time period. Upon reviewing documentation, the residents received timely notification and education on PREA.

The requested documentation was provided no further action needed. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision.

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

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As indicated in the PAQ, resident PREA education is not 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. It was further reported that the clients admitted to this program would not be eligible for admission if there was an identified disability or LEP.

Policy: Prison Rape Elimination Act (PREA), (pg. 9), states that "the appropriate education staff will provide youth under the Individuals with Disabilities Education Improvement Act (IDEA 2004) 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."

Policy 5.1 Juvenile Orientation states that "Facilities shall provide juvenile orientation in formats accessible to all juveniles, including those who are limited

	English proficient, deaf, visually impaired, or otherwise disabled, as well as to juveniles who have limited reading skills" (p.2). Residents sign an acknowledgment affirming they understand the agency/facility has a zero-tolerance policy toward all forms of sexual abuse and sexual harassment and policies and procedures in place to protect residents from victimization. Residents are encouraged to report it in person, in writing or by telephone. PREA Pamphlet Sign Off (30). The Pamphlet provides information on what a sexual assault is, how to avoid Rape, the allegation will be investigated, and what to do if you are sexually assaulted. Resident Handbook/brochure (English/Spanish): the resident handbook/brochure provides information to residents on information about sexual abuse and sexual harassment, an allegation will be investigated, how to avoid rape, what to do if you are sexually assaulted, how to make a report. No Means No Poster (English/Spanish): the poster provides information on how to make a report, who to report to and access to victim advocacy and emotional support services. Additionally, residents watch a PREA video designed by the PREA Resource Center (PREA Juvenile Comprehensive by PREA Resource Center) Resident Roster in the last 12 months provided a comprehensive list of residents housed at the facility in the last 12 months. The auditor was able to review the list to randomly select files to review. PREA Confirmation Signage (30) was reviewed documenting residents' receipt of PREA Education at Intake. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.333 (e). The agency shall maintain documentation of resident participation in these education sessions. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency maintains documentation of resident participation in the PREA education sessions. The facility has critical information continuously available to residents through posters, PREA handouts and meetings/ sessions with case managers or counselors.

PREA Pamphlet Sign Off (30). The Pamphlet provides information on what a sexual assault is, how to avoid Rape, the allegation will be investigated, and what to do if you are sexually assaulted.

PREA Confirmation Signage (30) was reviewed documenting residents' receipt of PREA Education at Intake.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision.

115.333 (f). In addition to providing such education, the agency shall ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats.

Compliance Determination:

The facility reported in the PAQ that the agency will ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats. Resident Handbook

Resident Handbook/brochure (English/Spanish): the resident handbook/brochure provides information to residents on information about sexual abuse and sexual harassment, an allegation will be investigated, how to avoid rape, what to do if you are sexually assaulted, how to make a report. A copy is also provided to the residents.

No Means No Poster (English/Spanish): the poster provides information on how to make a report, who to report to and access to victim advocacy and emotional support services.

Additionally, residents watch a PREA video designed by the PREA Resource Center (PREA Juvenile Comprehensive by PREA Resource Center)

Site Review:

Signage Clarity and Accessibility:
Signage about emotional and victim advocacy support services was available however needed some updated language. During the review, the site added new signage detailing these services and how to access them by phone or mail.
Signage is available in both English and Spanish.
The size, format, and placement of the signage accommodates most readers, including those with low vision or physical disabilities. Signage is posted in key areas such as resident spaces, education areas, and housing units. Information is also included in the PREA handbook given to residents at intake.
Signage is kept in good condition and is not obscured or damaged. Any damaged signage is promptly replaced.

	Accuracy and Consistency: The information on the signage, including phone numbers and mailing addresses, for outside reporting is accurate and consistent throughout the facility. Placement: Signage is strategically placed where it is accessible to residents, staff, and visitors. The auditor observed signage in administrative buildings, housing units, and educational areas. Informal Conversations: With Staff and Residents: Conversations confirmed that staff and residents are aware of the PREA posters and understand how to report incidents. It was also noted that staff and residents had limited knowledge about external victim advocacy and emotional support services. The facility has since implemented corrective actions to improve awareness and access to these services. Corrective Actions: · PREA Signage: Some of the signage was inconsistent in the facility. For example, in the gym there was signage in Spanish but not English. The updated signage also included any limitations to confidentiality and what would have to be reported. Corrective Action Taken: During the onsite assessment, the director placed additional signage up and provided pictures of the additional signage. In addition, the auditor observed the placement of additional signage in Education and in the gym. No further action is needed. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. The interim report indicated a need for corrective action to monitor the consistent compliance of residents receiving PREA Education within 10 days of placement at the facility. The facility has undergone several staffing changes which have impacted consistency in practice. The facility shall provide documentation on new intakes and the completion of PREA Education for the month in September and October. The requested documentation was provided no further action needed. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with the standard.

115.334	Specialized training: Investigations
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

The following evidence was analyzed in making compliance determination:

1. Documents:

a. Pre-Audit Questionnaire (PAQ)

b. Policy 1.29 Special Investigation Unit

c. Training Records (5)

d. Pacific Training Group Curriculum

2. Interviews:

a. Investigative staff - 1

Findings (By Provision):

115.334 (a). In addition to the general training provided to all employees pursuant to § 115.331, the agency shall ensure that, to the extent the agency itself conducts sexual abuse investigations, its investigators have received training in conducting such investigations in confinement settings.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As indicated in the PAQ, the agency/facility does not have trained investigators as all PREA-related investigations are conducted by an outside entity. The agency does not conduct any sexual abuse investigations. While the facility does not conduct investigations, the auditor recommended that a facility staff person complete the specialized training for investigations in the event the administrative component is not addressed by the outside investigator.

Policy 1.29 Special Investigation Unit states that “Southeast Alabama Youth Services shall require training of certain individuals as required in PREA Standard 115.334 Specialized training: Investigations” (p. 1).

Investigator Training Records (5)

Interviews

Investigative Staff: The interviewed staff reported that they received training specific to conducting sexual abuse and sexual harassment investigations in confinement settings. The training included: techniques for interviewing juvenile

	sexual abuse victims, proper use of Miranda and Garrity warnings, Sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative or prosecution referral. It should also be noted that at the time of the onsite audit, there was limited leadership staff and the Director also served as the onsite investigator, PREA compliance manager, and back up nurse. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.334 (b). Specialized training shall include techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Training records of five administrative investigators indicated that the investigative staff received the above-mentioned training. Interviews Investigative Staff: The interviewed staff reported that they received training specific to conducting sexual abuse and sexual harassment investigations in confinement settings. The training included: techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, Sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative or prosecution referral. The training was conducted online. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.334 (c). The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations. Compliance Determination: The facility has demonstrated compliance with this provision of the standard

	because: As reported in the PAQ, the agency maintains documentation showing that investigators have completed the required training. The number of investigators currently employed who have completed the required training: 4. Training Curriculum: Pacific Training Group provides the required specialized and general PREA training topics. The agency maintains documentation of investigator training records. The auditor reviewed training records of 5 staff certifications. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.334 (d). Auditor is not required to audit this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.335	**Specialized training: Medical and mental health care**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy: Training and Staff Development/Sexual Abuse/Assault/Harassment Training c. Specialized Training Certificate (7) d. Specialized Training Curriculum link on Training sign-in sheet e. General PREA Training (7)

2.Interviews:

Medical and Mental Health Staff (1)

1. Corrective Action:

a. Policy Update

Findings (By Provision):

115.335 (a). The agency shall ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in:(1) How to detect and assess signs of sexual abuse and sexual harassment;(2) How to preserve physical evidence of sexual abuse;(3) How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and(4) How and to whom to report allegations or suspicions of sexual abuse and sexual harassment.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

The agency has a policy related to the training of medical and mental health practitioners who work regularly in its facilities. The number of all medical and mental health care practitioners who work regularly at this facility received the training required by agency policy: 5.

Policy: Training and Staff Development/Sexual Abuse/Assault/Harassment Training: provides guidance on the agency requirement to ensure "SAYS employees shall receive specialized training in sexual abuse, sexual assault, and sexual harassment" (pp1-2). The policy further describes the training requirements for medical and mental health staff.

Training records (7): Reviewed and it was determined that personnel received specialized training for medical and mental health staff.

Interviews

Medical and Mental Health Staff: The interviewed staff reported that they completed the online training on sexual abuse and sexual harassment. The training included: how to detect and assess signs of sexual abuse and sexual harassment; how to preserve physical evidence of sexual abuse; how to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment; and how and whom to report allegations or suspicions of sexual abuse and sexual harassment.

Corrective Action:

· Policy: While the staff received the training the policy did not explicitly state the requirements.

	Corrective Action Implemented: During the post onsite audit phase, the agency updated its policy to include the specialized training requirements for medical and mental health staff. No further action is needed. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.335 (b). If medical staff employed by the agency conduct forensic examinations, such medical staff will receive the appropriate training to conduct such examinations. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, agency medical staff at this facility do not conduct forensic medical exams. The facility does not conduct forensic examinations. Forensic examinations if needed will be conducted at the local child advocacy center. Interviews Medical and Mental Health Staff: The staff interviewed reported that they do not complete forensic medical exams at this site; however, they have a previous job. N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.335 (c). The agency shall maintain documentation that medical and mental health practitioners have received the training referenced in this standard either from the agency or elsewhere. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, N/A is on the question if the facility maintains training records for the medical and mental health staff. Follow up with the PREA Coordinator indicated that the answer should have been yes. Training Records (7). A sample of seven staff records was reviewed and confirmed that the staff receive training as required by the standard. Corrective Action: N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.335 (d). Medical and mental health care practitioners shall also receive the training mandated for employees under § 115.331 or for contractors and volunteers under § 115.332, depending upon the practitioner's status at the agency.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

Training Records (7). A sample of seven staff records were reviewed and confirmed that the staff receives training as required by the provision.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

Overall Findings:

The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

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115.341 Obtaining information from residents

Auditor Overall Determination: Meets Standard

Auditor Discussion

The following evidence was analyzed in making compliance determination:

1. Documents:

a. Pre-Audit Questionnaire (PAQ)

b. Policy 13.8.1 Protection from Sexual Abuse and Assault

c. Southeast Alabama Youth Services/Screening for Vulnerability and Sexually Aggressive Behavior Blank

d. Completed Screenings (22)

e. Completed Rescreening (18)

2. Interviews:

a. Staff responsible for risk screening - 2

b. Random sample of residents - 10

c. PREA coordinator

d. PREA compliance manager

3. Corrective Action

a. Reassessments completed within 30 days. At least 60 days of documentation that reassessments are completed within the 30-day requirements (20)

b. Initial Assessments (12)

c. Staff Training

Findings (By Provision):

115.341 (a). Within 72 hours of the resident's arrival at the facility and periodically throughout a resident's confinement, the agency shall obtain and use information about each resident's personal history and behavior to reduce the risk of sexual abuse by or upon a resident.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the agency has a process in place of screening and support the residents in care. The policy requires that residents be screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their intake. The number of residents entering the facility (either through intake of transfer) within the past 12 months whose length of stay in the facility was for 72 hours or more and who were screened for risk of sexual victimization or risk of sexually abusing other residents within 72 hours of their entry into the facility: 52.

The facility has a policy governing the practice and procedures for screening residents. The screening process occurs in a setting that ensures privacy given the potentially sensitive information that is discussed. The screening location has adequate space, privacy, and time to conduct quality screening of the Resident for the desired information.

Policy 13.8.1 Protection for Sexual Abuse and Assault states that “all juveniles shall be screened within 24 hours of arrival at the facility utilizing SAYS Form 115.341 Intake Screening for Sexual Victimization and Abusiveness, to identify potential

	vulnerabilities or tendencies of acting out with sexually aggressive behavior" (p. 4). A review of 22 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 Southeast Alabama Youth Services/Screening for Vulnerability and Sexually Aggressive Behavior. A review of 19 records of residents who entered the program in the last 12 months provided evidence that while the rescreening was conducted, the rescreening's were not consistently conducted on the residents within 30 days of the initial screening. There were several documents requested that were not provided to the auditor, as they could not be located. Site Review PREA Risk Screening Since there were no new intakes during the site review, the auditor requested a mock intake demonstration to observe the PREA risk screening process. · Staff Responsibilities and Process: o The auditor confirmed that the case manager, mental health, and medical staff are responsible for conducting the PREA risk screening. In the absence of the case manager the director assisted with the intake process. o The screening takes place in the private office of the staff, ensuring confidentiality. Only the case management, medical, and mental health staff are present during the screening. o During the mock demonstration, the staff asked each question individually, periodically checking the residents' understanding and repeating responses to ensure accuracy. o The screening staff will not only ascertain information on the tool based on resident responses but also use subjective determination on the resident's perceived status related to sexual orientation and/or gender identity. o The screening staff uses an instrument that is designed to collect information during the screening process. o Screenings are documented electronically and on paper, placed in a secure client file accessible only to clinical staff and the facility director. The staff followed the screening instrument verbatim when asking questions. o Additionally, staff review the client file provided by DYS before placement, which may include information on criminal history, prior placements, psychological background, family history, and trauma history. Informal Conversations:

	· With Mental Health Staff: o The auditor asked how staff manage situations where a resident's information conflicts with the data provided by DYS. Staff reported that they would rephrase the question to clarify and emphasize the importance of honesty for effective treatment. They aim to create a comfortable environment for residents, recognizing that trust may develop over time, potentially leading to more accurate disclosures during reassessments. · With Residents: o Residents confirmed that they completed the PREA risk screening on their first day, conducted by the mental health staff in a private office. They reported being asked specific questions during the process. Interviews Staff Responsible for Risk Screening – The interviewed staff responsible for performing screening for risk of victimization and abusiveness reported that all residents are screened for risk of sexual abuse victimization or risk of sexually abusiveness toward other residents. The screening occurs immediately upon youth placement at the facility. The information is ascertained through conversations with residents, and intake documentation, along with the prior history provided in the referral packet. The staff reported that the nurse will conduct the PREA intake and the therapist will do a follow-up review with the client. Reassessments occur at 30 then 90 days; however, the clinical team reviews client cases weekly. Residents(s) in custody Interview Questionnaire: Out of the ten residents interviewed while in custody, all of the residents have been placed at the facility within the last year. All of the interviewed residents reported that upon admission, they were asked about prior history of sexual abuse, having any disabilities, whether they identify as being gay, bisexual, or transgender, or whether they think they may be in danger of sexual abuse. Only one of the ten residents reported being asked the same questions again. Corrective Actions: · Training: Conduct additional training sessions for all intake and classification staff to reinforce the importance of completing rescreening's within the PREA-mandated timelines. Due Date: 10/15/24 Corrective Action Implemented: The facility provided documentation of additional training to staff on the intake and classification process. The additional training was documented and uploaded into the audit system. · Reassessments: PREA Standard 115.341 mandates that all inmates must be screened for risk of sexual abuse or sexual victimization within 72 hours of intake and that a follow-up rescreening should occur within 30 days. The facility has identified that rescreening's are not consistently being completed within the required timeframe. The facility shall provide a list of new resident intakes for the

month of September and October. The facility shall upload initial and reassessment screenings for the new intakes. Due Date: November 11/15/2024.

Corrective Action Implemented: The facility provided documentation of new intakes (standard 115.333) and verification that assessments (12) and reassessments (20) were completed in a timely manner. The facility has a tool for both forms and also has weekly treatment team meetings for all residents. During those meetings staff go over placement, programming, housing, education and safety of a resident (documented in standard 115.342).

The requested documentation was provided no further action needed. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision.

115.341 (b). Such assessments shall be conducted using an objective screening instrument.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

The PAQ indicated that the facility utilizes a risk assessment that is an objective screening instrument.

The auditor reviewed Southeast Alabama Youth Services/Screening for Vulnerability and Sexually Aggressive Behavior and it was determined that the site is using an objective screening instrument. Objectivity was determined based on the following:

o Standardized Criteria: It uses pre-determined, clear, and measurable criteria for evaluating risk.

o Consistent Application: The instrument is applied uniformly to all individuals being assessed, ensuring that each person is evaluated using the same criteria and process.

o Quantifiable Metrics: There is a numerical scoring system with clearly defined categories to measure risk, reducing reliance on personal judgment.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.341 (c). At a minimum, the agency shall attempt to ascertain information about: (1) Prior sexual victimization or abusiveness; (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse; (3) Current charges and offense history; (4) Age; (5) Level of emotional and cognitive

development; (6) Physical size and stature; (7) Mental illness or mental disabilities; (8) Intellectual or developmental disabilities; (9) Physical disabilities; (10) The resident's own perception of vulnerability; and (11) Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

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

The assessment is conducted using an objective screening instrument. The Assessment ascertains the above information during the intake process.

Resident Records Reviewed (Vulnerability Assessment): 22.

PREA Risk Screening

Since there were no new intakes during the site review, the auditor requested a mock intake demonstration to observe the PREA risk screening process.

· Staff Responsibilities and Process:

o The auditor confirmed that the case manager, mental health, and medical staff are responsible for conducting the PREA risk screening. In the absence of the case manager the director assisted with the intake process.

o The screening takes place in the private office of the staff, ensuring confidentiality. Only the case management, medical, and mental health staff are present during the screening.

o During the mock demonstration, the staff asked each question individually, periodically checking the residents’ understanding and repeating responses to ensure accuracy.

o The screening staff will not only ascertain information on the tool based on resident responses but also use subjective determination on the resident’s perceived status related to sexual orientation and/or gender identity.

o The screening staff uses an instrument that is designed to collect information during the screening process.

o Screenings are documented on paper and electronically, placed in a secure client file accessible only to clinical staff and the facility director. The mental health staff follow the screening instrument verbatim when asking questions.

o Additionally, staff review the client file provided by DYS before placement, which may include information on criminal history, prior placements, psychological

background, family history, and trauma history.

Informal Conversations:

· With Mental Health Staff:

o The auditor asked how staff manage situations where a resident's information conflicts with the data provided by DYS. Staff reported that they would rephrase the question to clarify and emphasize the importance of honesty for effective treatment. They aim to create a comfortable environment for residents, recognizing that trust may develop over time, potentially leading to more accurate disclosures during reassessments.

· With Residents:

o Residents confirmed that they completed the PREA risk screening on their first day, conducted by the mental health staff in a private office. They reported being asked specific questions during the process.

Interviews

Staff Responsible for Risk Screening – The interviewed staff responsible for risk screening reported that the initial risk screening considers height, weight, sexual orientation, medical information, charges, institutional behavior, and prior sexual victimization. The information is ascertained through interviews and observation.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

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

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

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

The assessment is conducted using an objective screening instrument. The Assessment ascertains the above information during the intake process.

Resident Records Reviewed (Vulnerability Assessment): 22.

PREA Risk Screening

Since there were no new intakes during the site review, the auditor requested a mock intake demonstration to observe the PREA risk screening process.

· Staff Responsibilities and Process:

o The auditor confirmed that the case manager, mental health, and medical staff are responsible for conducting the PREA risk screening. In the absence of the case manager the director assisted with the intake process.

o The screening takes place in the private office of the staff, ensuring confidentiality. Only the case management, medical, and mental health staff are present during the screening.

o During the mock demonstration, the staff asked each question individually, periodically checking the residents' understanding and repeating responses to ensure accuracy.

o The screening staff will not only ascertain information on the tool based on resident responses but also use subjective determination on the resident's perceived status related to sexual orientation and/or gender identity.

o The screening staff uses an instrument that is designed to collect information during the screening process.

o Screenings are documented on paper and electronically, placed in a secure client file accessible only to clinical staff and the facility director. The mental health staff follow the screening instrument verbatim when asking questions.

o Additionally, staff review the client file provided by DYS before placement, which may include information on criminal history, prior placements, psychological background, family history, and trauma history.

Informal Conversations:

· With Mental Health Staff:

o The auditor asked how staff manage situations where a resident's information conflicts with the data provided by DYS. Staff reported that they would rephrase the question to clarify and emphasize the importance of honesty for effective treatment. They aim to create a comfortable environment for residents, recognizing that trust may develop over time, potentially leading to more accurate disclosures during reassessments.

· With Residents:

o Residents confirmed that they completed the PREA risk screening on their first day, conducted by the mental health staff in a private office. They reported being asked specific questions during the process.

Interviews

	Staff Responsible for Risk Screening - The interviewed staff responsible for risk screening reported that the information is ascertained by talking to residents, reviewing referral documentation, case files and incident reports. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.341 (e). The agency shall implement 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Site Review: o The auditor observed the location of the physical storage of the PREA screenings and medical documentation. The documents were placed in a locked file cabinet in the nurse’s station. The information is limited to the medical staff and to the site director. o The site uses paper instruments to complete PREA screenings and other intake medical related screenings. As previously discussed, the documents are held in a locked file cabinet in the nursing area. o There currently isn’t a nurse onsite however the director who is also a nurse is filling in for that vacancy. The director provided the auditor with access to see where the files were stored. In addition, full resident files for current and prior residents are locked in an office in a locked storage cabinet. Interviews PREA Coordinator – The interviewed PREA Coordinator reported that the agency allows all the clinical staff to review the resident assessments. PREA Compliance Manager- The staff interviewed reported that the information is limited to the clinical team. The information is stored in an electronic case management system. Staff Responsible for Risk Screening - The staff interviewed reported that the information is limited to the clinical team. The information is stored in an electronic case management system. Corrective Actions:

	N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. The interim report indicated a need for corrective action to monitor the consistent compliance of residents receiving risk assessment and reassessment within 72 hours and 30 days of placement at the facility, and training for intake staff. The facility has undergone several staffing changes which have impacted consistency in practice. The facility shall provide documentation on new intakes and the completion of assessments for the month of September and October. The requested documentation was provided no further action needed. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with standard.

115.342	**Placement of residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy 13.8.1 Protection from Sexual Abuse and Assault c. Southeast Alabama Youth Services/Screening for Vulnerability and Sexually Aggressive Behavior Blank d. Completed Screenings (22) 2. Interviews: a. PREA compliance manager b. PREA coordinator c. Staff responsible for Risk Screening – 2

	d. LGB Resident-1 e. Director f. Randomly Staff – 4 g. Medical and Mental Health -1 3. Corrective Action Documentation: a. Treatment Team Meeting Notes (October-December 2024) b. Exhaustive List of Assessments (12) and Reassessments (20) (Standard 115.341) Findings (By Provision): 115.342 (a). The agency shall use all information obtained pursuant to § 115.341 and subsequently to make housing, bed, program, education, and work assignments for residents with the goal of keeping all residents safe and free from sexual abuse. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As stated in the PAQ, the facility uses information from risk screening to inform housing, bed, work, education, and facility assignment with the goal of keeping the resident safe and free from sexual abuse. The facility uses PREA information to make determinations for all residents regarding housing, bed, work, education, and program assignments. The information is used to maintain separation between residents at risk of being sexually victimized and residents likely to commit sexual abuse. A review of the Southeast Alabama Youth Services/Screening for Vulnerability and Sexually Aggressive Behavior shows that residents housing and placement is based on risk level. The form provides guidance to staff based on the risk level and the type of room consideration that should take place. Interviews PREA Compliance Manager – The interviewed staff reported that the information from the risk screening during intake is used to determine placement and programming. The treatment team will review the intake information. Staff Responsible for Risk Screening – The interviewed staff reported that the agency/facility uses information from the risk screening to determine what room to place the residents in and what treatment services are needed. Corrective Actions:

	· Ongoing Review: While the treatment team has opportunity to review the risk assessment to determine housing and programming decisions. The facility shall provide documentation that the practice is done on a continuing and ongoing basis. The facility shall provide documentation of the treatment team meeting notes on new intakes for the month of September and October. Due Date: 11/15/2024. Corrective Action Implemented: The facility has submitted documentation of treatment team meetings over the course of three months during the corrective action period. These meetings covered key topics such as resident housing, programming, placement, education, and safety. The requested documentation was provided no further action needed. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility is fully compliant with this provision. 115.342 (b). Residents may be 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. During any period of isolation, agencies shall not deny residents daily large-muscle exercise and any legally 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As stated in the PAQ, the facility 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 facility policy requires that residents at risk of sexual victimization who are placed in isolation have access to legally required educational programming, special education services, and daily large-muscle exercise. The number of residents at risk of sexual victimization who were placed in isolation in the past 12 months: 0 The number of residents at risk of sexual victimization who were placed in isolation who have been denied daily access to large muscle exercise, and/or legally required education or special education services in the past 12 months: 0 The average period of time residents at risk of sexual victimization were held in isolation to protect them from sexual victimization in the past 12 months: 0 Policy 13.8.1 Protection for Sexual Abuse and Assault states “Juveniles alleging sexual assault may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other juveniles safe, and then only until an alternative means of keeping all juveniles safe can be arranged. During any

period of isolation, facilities shall not deny juveniles daily large-muscle exercise and any legally required educational programming or special education services. Juveniles in isolation shall receive daily visits from medical personnel or therapists. Juveniles shall also have access to other programs and work opportunities to the extent possible. Documentation of programming shall be maintained (p.6).

Reviews the Risk and Vulnerability Assessment: The residents PREA screening results, which assess their risk of sexual victimization and abusiveness, are considered.

Incorporates Findings into Housing and Programming Plans: Based on the assessment, housing assignments, room assignment, and programming decisions (including access to educational, vocational, and therapeutic programs) are made to ensure the safety of the individual and the overall facility. Special attention is given to separating high-risk individuals from potential perpetrators, while still meeting the rehabilitation and reentry goals of the resident.

Ongoing Review: The treatment team continuously monitors any changes in the president's behavior or circumstances and reviews the risk assessment as needed to adjust housing and programming decisions appropriately. The auditor was able to review two treatment team meeting notes showing where the assessment tool is reviewed and considered.

Interviews

Director: The interviewed director reported that they have not had any instances of isolation due to sexual abuse allegation. It was reported that they do not have an isolation room; and residents are not placed in isolation.

Medical and Mental Health Staff: The staff interviewed reported that if a resident was placed in isolation, they would continue to receive visits from medical and mental health staff. Nursing is in house so they would be able to visit as needed. The psychologist is offsite.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.342 (c). Lesbian, gay, bisexual, transgender, or intersex residents shall not be placed in particular housing, bed, or other assignments solely on the basis of such identification or status, nor shall agencies consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard

because:

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

Policy 13.8.1 Protection for Sexual Abuse and Assault states that "Lesbian, gay, bisexual, transgender, or intersex juveniles shall not be placed in a particular unit/room, or other assignments solely on the basis of such identification or status, nor shall facilities consider lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator of likelihood of being sexually abusive" (p. 6).

Interviews

PREA Coordinator - The interviewed PREA Coordinator reported that the facility does not have a special housing unit for lesbian, gay, bisexual, transgender, or intersex residents.

PREA Compliance Manager – The interviewed staff reported that the facility does not have specialized housing units for lesbian, gay, bisexual, transgender, or intersex residents.

Gay, Lesbian, and bisexual resident(s) in custody: There were no identified residents during the onsite portion of the audit.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.342 (d). In deciding whether to assign a transgender or intersex resident to a facility for male or female residents, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the resident's health and safety, and whether the placement would present management or security problems.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, in deciding whether to assign a transgender or intersex resident to a facility for male or female residents, the agency shall consider on a case-by-case basis whether a placement would ensure the resident's health and safety. In making housing and programming assignments, the facility shall consider on a case-by-case basis whether a placement of a transgender or intersex resident would present management or security problems.

	Policy 13.8.1 Protection for Sexual Abuse and Assault states that "In deciding whether to assign a transgender or intersex juvenile to a facility for male or female juveniles, and in making other housing and programming assignments, the agency shall consider, on a case-by-case basis, whether a placement would ensure the juvenile's health and safety, and whether the placement would present management or security problems" (p.6) Interviews PREA Compliance Manager – The interviewed staff reported that the treatment team will meet and review and go over all of the identified needs or concerns. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.342 (e). Placement and programming assignments for each transgender or intersex resident shall be reassessed at least twice each year to review any threats to safety experienced by the resident. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Interviews PREA Compliance Manager – The interviewed staff reported that room assignments are determined based on the resident's safety. Due to the small number of residents onsite, all residents are individually assessed. Staff Responsible for Risk Screening - The interviewed staff responsible for risk screening reported that safety is given serious consideration in placement and programming assignment of transgender or intersex residents. We will talk to the residents to determine the best course of action for room assignment or treatment services. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.342 (f). Transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration. Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: Interviews PREA Compliance Manager – The interviewed staff reported that room assignments are determined based on the resident's safety. Yes, for example, we have a resident onsite that was getting bullied and can't get along with others so we adjusted room assignment for his safety. Staff Responsible for Risk Screening - The interviewed staff responsible for risk screening reported that transgender and intersex are residents given the opportunity to shower separately from other residents. It was further reported that all residents shower separately. All residents shower separately. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.342 (g). Transgender and intersex residents shall be given the opportunity to shower separately from other residents. Compliance Determination: Interviews PREA Compliance Manager - Placement and programming assignments for each transgender or intersex resident is reviewed at the treatment team meeting; every other week. Staff Responsible for Risk Screening - The interviewed staff responsible for risk screening reported that if a screening indicates that a resident has experienced prior sexual victimization, whether in an institutional setting or in the community, the clinical team will meet with the resident within 24 hours and document in the case notes. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.342 (h). If a resident is isolated pursuant to paragraph (b) of this section, the facility shall clearly document: (1) The basis for the facility's concern for the resident's safety; and (2) The reason why no alternative means of separation can be arranged.

	Compliance Determination: The PAQ indicated that there were zero residents at risk of sexual victimization who were held in isolation in the past 12 months. The facility does not utilize isolation. N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.342 (i). Every 30 days, the facility shall afford a review of each resident described in paragraph (h) of this section a review to determine whether there is a continuing need for separation from the general population. Compliance Determination: As reported in a PAQ, if a resident at risk of sexual victimization is held in isolation, the facility affords each such resident a review every 30 days to determine whether there is a continuing need for separation from the general population. Policy 13.8.1 Protection for Sexual Abuse and Assault states that "Every 30 days, the facility shall afford each juvenile described in paragraph #8 a review to determine whether there is a continuing need for separation from the general population" (p. 6). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. The interim report indicated a need for corrective action to monitor the consistent compliance of documentation the use risk assessments to determine programming, placement, and housing decisions. The facility shall provide documentation on new intakes and the completion of assessments, and the treatment plan used to document said decisions for the month of September and October. The requested documentation has been provided, and no further action is required. After a thorough review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with the standard.

115.351	Resident reporting
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Resident Handbook (English/Spanish) c. First Responder Card d. Verbal Report e. Critical Incident Report f. Policy 13.8.1 (a) Immigration g. MOU House of Ruth Southeast Alabama h. Third Party Reporting Form 2. Interviews: a. Random sample of staff - 10 b. Random sample of residents - 8 c. PREA compliance manager d. Residents who Reported a Sexual Abuse 3. Corrective Action: a. Retrain staff Findings (By Provision): 115.351 (a). The agency shall provide multiple internal ways for residents to privately report sexual abuse and sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency has established procedures allowing for multiple internal ways for residents to report privately to agency officials about: • sexual

	abuse and sexual harassment; • retaliation by other residents or staff for reporting sexual abuse and sexual harassment; AND • staff neglect or violation of responsibilities that may have contributed to such incidents. Resident Handbook (English/Spanish). The resident handbook provides: You can speak with or send a note to any of the following: Ø Staff Member Ø Nurse Ø Your Probation Officer Ø Your Attorney Ø Your Parents/Legal Guardian Or you can make a report by: 1. Filing a grievance with the SAYS PREA Coordinator. 2. Calling the House of Ruth at 334-793-2232 or 1-800-650-6522 [AVAILABLE 24/7] 3. Calling the Southeast Alabama Child Advocacy Center at (334) 671-1779. ALL SAYS Facilities have a confidential process where counselors are notified that you need to speak with them. All facility staff members know what to do if you have been harmed and how to help you become safe (p.14). In review of the student handbook, there are multiple ways provided for the youth to report sexual abuse or sexual harassment. Additionally, the facility provided copies of the FACILITY grievance forms. The grievance process is one of many ways in which a resident could report sexual abuse or sexual harassment. PREA Pamphlet Sign Off (30). The Pamphlet provides information on what a sexual assault is, how to avoid Rape, the allegation will be investigated, and what to do if you are sexually assaulted. Resident Handbook brochure (English/Spanish): the resident handbook/brochure provides information to residents on information about sexual abuse and sexual harassment, an allegation will be investigated, how to avoid rape, what to do if you are sexually assaulted, how to make a report. No Means No Poster (English/Spanish): the poster provides information on how to make a report, who to report to and access to victim advocacy and emotional support services. Site Review: During the site review, the auditor noted the following:

	Signage Clarity and Accessibility: Signage about emotional and victim advocacy support services was not available at first. During the review, the site added new signage detailing these services and how to access them by phone or mail. Signage is available in both English and Spanish. The size, format, and placement of the signage accommodates most readers, including those with low vision or physical disabilities. Signage is posted in key areas such as resident spaces, education areas, and housing units. Information is also included in the PREA handbook given to residents at intake. In the gym and in the school some of the signage was not available in English and Spanish. Signage is kept in good condition and is not obscured or damaged. Any damaged signage is promptly replaced. The signage contained information on how to make a report and who to make a report to, and victim advocacy and emotional support. Accuracy and Consistency: The information on the signage, including phone numbers and mailing addresses, for outside reporting is accurate and consistent throughout the facility. The agency's site contact information needed to be updated. Placement: Signage is strategically placed where it is accessible to residents, staff, and visitors. The auditor observed signage in administrative buildings, housing units, and educational areas. Informal Conversations: With Staff and Residents: Conversations confirmed that staff and residents are aware of the PREA posters and understand how to report incidents. It should be noted that staff reported that they could anonymously report using the grievance box as well. It was also noted that staff and residents had limited knowledge about external victim advocacy and emotional support services. The facility has since implemented corrective actions to improve awareness and access to these services. Testing Internal Reporting Methods for Confined Persons · Internal Reporting: o The auditor assessed the internal reporting methods by contacting the phone numbers listed on the facility's posters. It was confirmed that residents can call the hotline to make a report, and if an allegation is made, the Department of Youth Services (DYS) will notify the facility to initiate an investigation. Calls made to the national hotline are redirected to the state DYS. · Written Reporting: o Residents can submit written reports by writing a letter to any staff member or by filing a grievance. Each housing unit has a DYS grievance box with forms available in both English and Spanish, ensuring residents have easy daily access to submit grievances. o Informal conversations with residents confirmed that they have access to writing

materials and can either place their grievance in the box or submit a written statement under the door of the mental health staff.

· Electronic Reporting:

o The facility does not currently offer electronic means for residents to report allegations of sexual abuse or harassment.

· Verbal Reporting:

o During informal and formal conversations, residents reported that they can verbally report incidents to any staff member or the DYS advocate, and they feel comfortable approaching trusted staff privately.

o Staff consistently reported that residents can verbally report allegations at any time, and if they receive a report, they notify their supervisor immediately and document the allegation without delay.

Processes for Sending and Receiving Mail (Mail Drop Boxes/Mailroom)

· Outgoing Mail:

o The auditor observed that residents have ready access to paper and pencils for writing letters. The outgoing mail process is as follows:

§ Residents write a letter, place it in an envelope obtained from the mental health staff, who then deliver it to administrative staff.

§ Administrative staff verify that the letter is addressed to an approved authority.

§ The mail clerk confirmed that resident mail is not read before being sent. They simply place a stamp on the envelope and ensure the mail is sent.

· Incoming Mail:

o Incoming mail follows a similar process. The mail clerk verifies that it is from an approved party, and residents open their mail in front of staff, shaking the envelope to ensure nothing is concealed.

o While the facility does not have a locked or secured mail drop box, all incoming and outgoing mail is logged, which the auditor observed. Mail access is managed by an administrative staff/mail clerk.

Record Storage

· Risk Screening Process:

o The risk screening and other assessment tools (e.g., DYS assessment, biopsychosocial evaluations, treatment plans) are securely stored in an electronic case management system, with access limited to clinical staff and facility directors. The electronic system is password protected.

	· Access Control: o Informal conversations with staff confirmed that access to the case management system, particularly the assessments, is restricted to clinical staff and facility leadership only. Interviews Random Sample of Staff - The interviewed staff reported various ways in which they could privately report sexual abuse or sexual harassment of residents. Such methods include calling the PREA Director, hotline number, supervisor, or grievance box. Residents(s) in custody Interview Questionnaire: The interviewed residents reported various methods to report sexual abuse or sexual harassment that happened to them or someone else by notify staff, write a letter, call the hotline, grievance, notify the PREA officer, or tell their family. DYS Advocate: The auditor conducted an informal interview with a DYS advocate. The advocate provided the auditor with the process used to review the grievances, meet with the youth and if there is a PREA related grievance they would immediately report the incident to the site leadership. Corrective Actions: · Resident Education: Upon review of the information provided to residents at intake the auditor recommended that the site also provide the mailing address to the outside reporting entity (Ruth House). Corrective Action Implemented: The brochure was updated. No further action is needed. 115.351 (b). The agency shall also provide at least one way for residents to report abuse or harassment to a public or private entity or office that is not part of the agency and that is able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials, allowing the resident to remain anonymous upon request. Residents detained solely for civil immigration purposes shall be provided with information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the facility provides more than one way for residents to report abuse or harassment to a public or private entity that is not part of the agency. Resident Handbook (English/Spanish). The resident handbook provides:

	You can speak with or send a note to any of the following: Ø Staff Member Ø Nurse Ø Your Probation Officer Ø Your Attorney Ø Your Parents/Legal Guardian Or you can make a report by: 4. Filing a grievance with the SAYS PREA Coordinator. 5. Calling the House of Ruth at 334-793-2232 or 1-800-650-6522 [AVAILABLE 24/7] 6. Calling the Southeast Alabama Child Advocacy Center at (334) 671-1779. ALL SAYS Facilities have a confidential process where counselors are notified that you need to speak with them. All facility staff members know what to do if you have been harmed and how to help you become safe (p.14). Policy 13.8.1 (a) Immigration provides guidance to the agency if a resident is solely for civil immigration purposes. The facility has a MOU with House of Ruth Southeast Alabama. The MOU provides an outside reporting agreement where the residents can report to the agency and further communication with the agency PREA Coordinator on any allegations. Site Review: During the site review, the auditor noted the following: Signage Clarity and Accessibility: Signage about emotional and victim advocacy support services was not available at first. During the review, the site added new signage detailing these services and how to access them by phone or mail. Signage is available in both English and Spanish but was not consistent in all locations. The size, format, and placement of the signage accommodates most readers, including those with low vision or physical disabilities. Signage is posted in key areas such as resident spaces, education areas, and housing units. Information is also included in the PREA handbook given to residents at intake. Signage is kept in good condition and is not obscured or damaged. Any damaged signage is promptly replaced. The signage contained information on how to make a report and who to make a report Accuracy and Consistency:

	The information on the signage, including phone numbers and mailing addresses, for outside reporting is accurate and consistent throughout the facility. Placement: Signage is strategically placed where it is accessible to residents, staff, and visitors. The auditor observed signage in administrative buildings, housing units, and educational areas. Informal Conversations: With Staff and Residents: Conversations confirmed that staff and residents are aware of the PREA posters and understand how to report incidents. It was also noted that staff and residents had limited knowledge about external victim advocacy and emotional support services. The facility has since implemented corrective actions to improve awareness and access to these services. Reporting via Phone: · Phone Access: Residents do not have unrestricted access to a phone. Instead, they must request permission from mental health staff to use the phone for external reporting. · Auditor's Test: The auditor assessed the external reporting method by calling the listed hotline as a resident would. The test confirmed the following: The staff phone that residents use to make a report is functional. The phone number on the signage connects directly to the external reporting entity. Reporting does not require the resident to provide their name; however, they must request phone access through staff, typically mental health staff. The hotline number is local/toll-free, answered by a live person, and available 24/7. The external reporting entity is equipped to receive reports of sexual abuse and harassment from residents and promptly forwards reports to agency officials. During the test, the auditor spoke with a representative who confirmed that residents can make reports and that the facility would be notified if pertinent information is provided. The reporting entity also confirmed that residents can report anonymously upon request. · Phone Call Privacy: While residents can access a phone through staff, informal conversations with staff indicated that when a resident requests to call the hotline, staff allow for confidentiality by stepping away, though they maintain a line of sight for supervision. · Monitoring Other Calls: Calls to parents and individuals on the approved list are monitored. Informal conversations with staff confirmed that phone calls are monitored to ensure compliance with the approved contact list. However, if a resident requests to call the hotline, staff will dial the number and then provide some privacy by stepping away while maintaining visual supervision.

	Residents, during informal conversations, reported that while calls are generally monitored, they believe they could have a confidential conversation if needed. Testing Internal Reporting Methods for Confined Persons Written Reporting: o Residents can submit written reports by writing a letter to any staff member or by filing a grievance. Each housing unit has a DYS grievance box with forms available in both English and Spanish, ensuring residents have easy daily access to submit grievances. o Informal conversations with residents confirmed that they have access to writing materials and can either place their grievance in the box or submit a written statement under the door of the mental health staff. Electronic Reporting: o The facility does not currently offer electronic means for residents to report allegations of sexual abuse or harassment. Verbal Reporting: o During informal and formal conversations, residents reported that they can verbally report incidents to any staff member or the DYS advocate, and they feel comfortable approaching trusted staff privately. o Staff consistently reported that residents can verbally report allegations at any time, and if they receive a report, they notify their supervisor immediately and document the allegation without delay. Processes for Sending and Receiving Mail (Mail Drop Boxes/Mailroom) o Outgoing Mail: o The auditor observed that residents have ready access to paper and pencils for writing letters. The outgoing mail process is as follows: o Residents write a letter, place it in an envelope obtained from the mental health staff, who then deliver it to administrative staff. o Administrative staff verify that the letter is addressed to an approved authority. o The mail clerk confirmed that resident mail is not read before being sent. They simply place a stamp on the envelope and ensure the mail is sent. o Incoming Mail: o Incoming mail follows a similar process. The mail clerk verifies that it is from an approved party, and residents open their mail in front of staff, shaking the envelope to ensure nothing is concealed. o While the facility does not have a locked or secured mail drop box, all incoming

and outgoing mail is logged, which the auditor observed. Mail access is managed by an administrative staff/mail clerk.

Record Storage

Risk Screening Process:

o The risk screening and other assessment tools (e.g., DYS assessment, biopsychosocial evaluations, treatment plans) are securely stored in an electronic case management system, with access limited to clinical staff and facility directors. The electronic system is password protected.

Access Control:

o Informal conversations with staff confirmed that access to the case management system, particularly the assessments, is restricted to clinical staff and facility leadership only.

Interviews

PREA Compliance Manager – The interviewed staff reported that residents can call the hotline number or the House of Ruth.

Residents(s) in custody Interview Questionnaire: All of the interviewed residents could identify at least one person outside of the facility to whom they could report sexual abuse or sexual harassment. The various methods include calling the family, hotline, telling the DYS advocate, or probation officer. Seven of the ten residents further reported that they could make a report without giving their name. The various ways were written a grievance without putting your name on it or calling the hotline

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.351 (c). Staff shall accept reports made verbally, in writing, anonymously, and from third parties and shall promptly document any verbal reports.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

The facility 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. It further reported that staff are required to document verbal reports within 48 hours.

Policy 13.8.1 Protection for Sexual Abuse and Assault states that “the agency has a policy mandating that staff accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously and from third parties” (p. 8).

The facility has a third-party reporting form (English/Spanish)

Submitted Verbal Reports (1)

Completed Critical Incident Report (1)

Interviews

Random Sample of Staff - The interviewed staff report that when a resident alleges sexual abuse, they can do so verbally, in writing, anonymously and from third parties. They further reported that such allegations would be documented immediately. The staff were able to further describe that residents could verbally tell staff, family, or anyone they trust; they could use the same process to write a letter. The staff reported that anyone could make a report for them and anonymously they could write a grievance. When probed two staff reported not being clear how residents could make a third-party report.

Residents(s) in custody Interview Questionnaire: The interviewed residents reported that they can make a report of sexual abuse or sexual harassment either in person or in writing by notifying family or their PO. The residents felt they could tell any trusted staff, DYS worker or call the hotline; write a written grievance or have their family report for them.

Corrective Actions:

· Policy: During the documentation review stage, it was determined that policy did not explicitly address the above-mentioned provision.

Corrective Action Implemented: The facility updated policy to address the language of the provision. No further action is required.

· Recommend retraining staff to include supervisors on the requirement to make announcements when opposite gender staff come to the housing unit.

Corrective Action Implemented: The facility provided documentation, indicating that on 10/1/2024 staff were provided refresher training on: Opposite Gender Announcements, Evidence Protocol, Age of Consent and Third-Party Reporting. According to the roster, 17 staff received training. No further action is required.

115.351 (d). The facility shall provide residents with access to tools necessary to make a written report.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the facility provides residents with access to tools to make written reports of sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents.

Residents sign an acknowledgment form confirming they have been provided with information related to reporting. The Zero Tolerance Policy for Sexual Harassment and Sexual Abuse Acknowledgment, affirms that resident understands reporting allegations of sexual abuse. The statement encourages Residents to report. Residents have ready access to pen, paper, and grievance forms.

PREA Audit Site Review: The auditor observed a locked grievance box in the resident housing area. There were readily available grievance forms for the youth to access.

Interviews

PREA Compliance Manager: The interviewed staff reported that residents can call the hotline, write a grievance, or make a verbal report to staff of sexual abuse or harassment or retaliation.

Residents who Reported a Sexual Abuse: There was one resident identified that reported sexual harassment. The resident stated that staff assisted him with writing a statement.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.351 (e). The agency shall provide a method for staff to privately report sexual abuse and sexual harassment of residents.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

The facility 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. Staff are informed of these procedures in the following ways: orientation, in service, day-to-day communication with the compliance manager.

The facility has first responder cards that provide a process of what action steps should be taken upon an allegation being made.

Interviews

Random Sample of Staff - The interviewed staff report that when a resident alleges

	sexual abuse, they can do so verbally, in writing, anonymously and from third parties. They further reported that such allegations would be documented immediately. The staff were able to further describe that residents could verbally tell staff, family, or anyone they trust; they could use the same process to write a letter. The staff reported that anyone could make a report for them and anonymously they could write a grievance. When probed two staff reported not being clear how residents could make a third-party report. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.352	**Exhaustion of administrative remedies**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy 1.28 Youth Grievance Process c. Resident Handbook d. Third Party Reporting Form (English/Spanish) e. DYS Grievance Form f. DYS Grievance Policy 2. Interviews: a. Resident who Reported Sexual Abuse 3. Corrective Action:

a. Staff Training

Findings (By Provision):

115.352 (a). An agency shall be exempt from this standard if it does not have administrative procedures to address resident grievances regarding sexual abuse.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the agency has an administrative process for dealing with resident grievances regarding sexual abuse and is not exempt from this standard.

Policy 1.28 Youth Grievances Process provides guidance on how the agency will respond to grievances related to sexual abuse. It should also be noted that the State of Alabama juvenile justice has an advocacy program where agency advocates outside of the facility review and respond to grievances.

Interviews:

DYS Advocate: The auditor conducted an informal interview with a DYS advocate. The advocate provided the auditor with the process used to review the grievances, meet with the youth and if there is a PREA related grievance they would immediately report the incident to the site leadership.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.352 (b). (1) The agency shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse. (2) The agency may apply otherwise-applicable time limits on any portion of a grievance that does not allege an incident of sexual abuse. (3) The agency shall not require a resident to use any informal grievance process, or to attempt to resolve with staff an alleged incident of sexual abuse. (4) Nothing in this section shall restrict the agency's ability to defend against a lawsuit filed by a resident on the ground that the applicable statute of limitations has expired.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the agency policy or procedure allows a resident to submit a grievance regarding an allegation of sexual abuse at any time regardless of when the incident is alleged to have occurred. The PAQ further states that agency policy

requires a resident to use an informal grievance process, or otherwise to attempt to resolve with staff, an alleged incident of sexual abuse.

While the PAQ stated that the policy requires a resident to use the informal grievance process to resolve allegations involving staff, Policy 1.28 Youth Grievances states that “SAYS Advocacy shall not require a juvenile to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse” (p. 4).

The resident handbook provides further guidance to the youth on their ability to file grievances for allegations of sexual abuse and sexual harassment.

The DYS Policy further states that “no time limit exists when a youth may submit Grievance regarding an allegation of Sexual Abuse” (p. 8).

Blank DYS Grievance Form

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.352 (c). The agency shall ensure that (1) A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint, and (2) Such grievance is not referred to a staff member who is the subject of the complaint.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

The agency reported in the PAQ that the agency's policy and procedure allow a resident to submit a grievance alleging sexual abuse without submitting it to the staff member who is the subject of the complaint.

Policy 1.28 Youth Grievance Process states that “SAYS Advocacy Representatives shall ensure that juveniles who allege sexual abuse may submit a grievance without submitting it to a staff member who is subject of the complaint” (p. 4).

12-month grievances (reviewed onsite there were none PREA related)

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.352 (d). (1) The agency shall 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. (2) Computation of the 90-day time period shall not include time consumed by residents in preparing any administrative appeal. (3) The agency may claim an extension of time to respond, up to 70 days, if the normal time period for response is insufficient to make an appropriate decision. The agency shall notify the resident in writing of any such extension and provide a date by which a decision will be made. (4) 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, the resident may consider the absence of a response to be a denial at that level. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency's policy and procedures require that a decision on the merits of any grievance or portion of a grievance alleging sexual abuse be made within 90 days of the filing of the grievance. In the past 12 months, the number of grievances that were filed that alleged sexual abuse: 5. In the past 12 months, the number of grievances alleging sexual abuse reached final decision within 90 days after being filed: 5. In the past 12 months, the number of grievances alleging sexual abuse involved extensions because final decision was not reached within 90 days: 0. Policy 1.28 Youth Grievance Process states that “SAYS Advocacy shall issue a final decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filling of the grievance” (p. 4). The DYS Policy further confirms the above requirements in that it states that “a final decision on the merits of any portion of a Grievance alleging Sexual Abuse comes within 90 days of the initial filling of the Grievance”. “Computation of the time period excludes time utilized by Youth in preparing any administrative appeal” (p. 8). While the facility uploaded five incidents that were reported by PREA, none of the incidents appeared to have been reported through the grievance process. Interviews: Residents who Reported a Sexual Abuse: There was one resident onsite who reported sexual harassment. The resident stated that the staff member told him it would be PREA investigated. The incident was reported two days ago and the staff have not notified me as of yet of the decision of the allegation. The incident involved another resident.

	Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.352 (e). (1) Third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, shall be permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of residents. (2) 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. (3) If the resident declines to have the request processed on his or her behalf, the agency shall document the resident's decision. (4) A parent or legal guardian of a juvenile shall be allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile. Such a grievance shall not be conditioned upon the juvenile agreeing to have the request filed on his or her behalf. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The facility reported in the PAQ that the aagency policy and procedure permits third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse, and to file such requests on behalf of residents. The number of grievances alleging sexual abuse filed by residents in the past 12 months in which the resident declined third-party assistance, containing documentation of the resident's decision to decline: 0 Policy 1.28 Youth Grievance Process states that “third parties, including fellow youths, staff members, family members, attorneys, and outside advocates, shall be permitted to assist residents in filling grievances relating to allegations of sexual abuse, and shall also be permitted to file such requests on behalf of youths” (p. 4). The policy provides additional guidance on third party reporting processes. Third Party Reporting Form (English/Spanish) The resident handbook further provides guidance on the youth’s ability to have a third-party file a grievance on their behalf. The DYS policy further confirms the above in that third parties, including fellow youth, staff members, family members, attorneys, and outside advocates are

	permitted to assist residents in filling grievances that allege sexual abuse (p. 8). 12-month grievances (reviewed onsite) Site Review: During the site review, the auditor noted the following: Signage Clarity and Accessibility: Signage about emotional and victim advocacy support services was not available at first. During the review, the site added new signage detailing these services and how to access them by phone or mail. Signage is available in both English and Spanish however not consistent in all locations. The size, format, and placement of the signage accommodates most readers, including those with low vision or physical disabilities. Signage is posted in key areas such as resident spaces, education areas, and housing units. Information is also included in the PREA handbook given to residents at intake. Signage is kept in good condition and is not obscured or damaged. Any damaged signage is promptly replaced. The signage contained information on how to make a report and who to make a report Accuracy and Consistency: The information on the signage, including phone numbers and mailing addresses, for outside reporting is accurate and consistent throughout the facility. Placement: Signage is strategically placed where it is accessible to residents, staff, and visitors. The auditor observed signage in administrative buildings, housing units, and educational areas. Informal Conversations: With Staff and Residents: Conversations confirmed that staff and residents are aware of the PREA posters and understand how to report incidents. It was also noted that staff and residents had limited knowledge about external victim advocacy and emotional support services. The facility has since implemented corrective actions to improve awareness and access to these services. Reporting via Phone: · Phone Access: Residents do not have unrestricted access to a phone. Instead, they must request permission from mental health staff to use the phone for external reporting. · Auditor's Test: The auditor assessed the external reporting method by calling the listed hotline as a resident would. The test confirmed the following: The staff phone that residents use to make a report is functional. The phone number on the signage connects directly to the external reporting entity.

	Reporting does not require the resident to provide their name; however, they must request phone access through staff, typically mental health staff. The hotline number is local/toll-free, answered by a live person, and available 24/7. The external reporting entity is equipped to receive reports of sexual abuse and harassment from residents and promptly forwards reports to agency officials. During the test, the auditor spoke with a representative who confirmed that residents can make reports and that the facility would be notified if pertinent information is provided. The reporting entity also confirmed that residents can report anonymously upon request. · Phone Call Privacy: While residents can access a phone through staff, informal conversations with staff indicated that when a resident requests to call the hotline, staff allow for confidentiality by stepping away, though they maintain a line of sight for supervision. · Monitoring Other Calls: Calls to parents and individuals on the approved list are monitored. Informal conversations with staff confirmed that phone calls are monitored to ensure compliance with the approved contact list. However, if a resident requests to call the hotline, staff will dial the number and then provide some privacy by stepping away while maintaining visual supervision. Residents, during informal conversations, reported that while calls are generally monitored, they believe they could have a confidential conversation if needed. Testing Internal Reporting Methods for Confined Persons Written Reporting: o Residents can submit written reports by writing a letter to any staff member or by filing a grievance. Each housing unit has a DYS grievance box with forms available in both English and Spanish, ensuring residents have easy daily access to submit grievances. o Informal conversations with residents confirmed that they have access to writing materials and can either place their grievance in the box or submit a written statement under the door of the mental health staff. Electronic Reporting: o The facility does not currently offer electronic means for residents to report allegations of sexual abuse or harassment. Verbal Reporting: o During informal and formal conversations, residents reported that they can verbally report incidents to any staff member or the DYS advocate, and they feel comfortable approaching trusted staff privately. o Staff consistently reported that residents can verbally report allegations at any

	time, and if they receive a report, they notify their supervisor immediately and document the allegation without delay. Processes for Sending and Receiving Mail (Mail Drop Boxes/Mailroom) o Outgoing Mail: o The auditor observed that residents have ready access to paper and pencils for writing letters. The outgoing mail process is as follows: o Residents write a letter, place it in an envelope obtained from the mental health staff, who then deliver it to administrative staff. o Administrative staff verify that the letter is addressed to an approved authority. o The mail clerk confirmed that resident mail is not read before being sent. They simply place a stamp on the envelope and ensure the mail is sent. o Incoming Mail: o Incoming mail follows a similar process. The mail clerk verifies that it is from an approved party, and residents open their mail in front of staff, shaking the envelope to ensure nothing is concealed. o While the facility does not have a locked or secured mail drop box, all incoming and outgoing mail is logged, which the auditor observed. Mail access is managed by an administrative staff/mail clerk. Record Storage Risk Screening Process: o The risk screening and other assessment tools (e.g., DYS assessment, biopsychosocial evaluations, treatment plans) are securely stored in an electronic case management system, with access limited to clinical staff and facility directors. The electronic system is password protected. Access Control: o Informal conversations with staff confirmed that access to the case management system, particularly the assessments, is restricted to clinical staff and facility leadership only. o There are grievance forms and a locked box available to the residents however the facility does not use the grievance system for allegations of sexual abuse and sexual harassment. If a grievance is completed for said allegation it is immediately turned over to investigations. Corrective Actions: · During the interview process, staff did not appear consistently sure of the president’s ability to have a third party submit an allegation of sexual abuse or

sexual harassment. The facility shall provide additional training to staff on the ability to file a third-party report.

Corrective Action Implemented: Documentation of training provided to staff on 10/1/2024 on third party report. No further action is required.

115.352 (f). 1) The agency shall establish procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. (2) After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, the agency shall 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, shall provide an initial response within 48 hours, and shall issue a final agency decision within 5 calendar days. The initial response and final agency decision shall document the agency's determination whether the resident is at substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

The agency reported in the PAQ that the agency has a policy and established procedures for filing an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse. The agency's policy and procedure for emergency grievances alleging substantial risk of imminent sexual abuse require that a final agency decision be issued within 5 days.

The number of emergency grievances alleging substantial risk of imminent sexual abuse that were filed in the past 12 months: 0The number of those grievances in 115.352(f)-3, which had an initial response within 48 hours: 0

The number of grievances alleging substantial risk of imminent sexual abuse filed in the past 12 months that reached final decisions within 5 days: 0

Policy 1.28 Youth Grievance Process provides detailed guidance on the emergency grievance process. The policy provides a timeline for a response and how the agency would respond.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.352 (g). The agency may discipline a resident for filing a grievance related to alleged sexual abuse only where the agency demonstrates that the resident filed the grievance in bad faith.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ the agency has a written policy that limits its ability to discipline a resident for filing a grievance alleging sexual abuse to occasions where the agency demonstrates that the resident filed the grievance in bad faith.

In the past 12 months, the number of resident grievances alleging sexual abuse resulted in disciplinary action by the agency against the resident for having filed the grievance in bad faith: 0.

Policy 1.28 Youth Grievance Process states that "facilities may discipline a youth for filing a grievance related to alleged sexual abuse/assault/harassment only where the facility demonstrates that the juvenile filed the grievance in bad faith. The facility shall use the regular disciplinary actions and pre-established sanctions should be applied" (p. 5).

Corrective Actions:

N/A. There are no corrective actions for this provision.

Overall Findings:

The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.353	Resident access to outside confidential support services and legal representation
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy 13.8.1 Protection for Sexual Abuse and Assault c. Resident Handbook

d. No Means No Poster

e. PREA Pamphlet

f. MOU Southeast Alabama Child Advocacy Center (CAC)

g. MOU House of Ruth

2. Interviews:

a. Random sample of residents - 8

b. Director

c. PREA Compliance Manager

d. Advocacy Center

e. Residents who Reported a Sexual Abuse

3. Corrective Action:

a. Resident Education

b. PREA Posters

Findings (By Provision):

115.353 (a). The facility shall provide residents with access to outside victim advocates for emotional support services related to sexual abuse, by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations, and, for persons detained solely for civil immigration purposes, immigrant services agencies. The facility shall enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the facility provides residents with access to an outside victim advocate for emotional supportive services related to sexual abuse. It further reports that the facility provides residents with access to such services by giving residents (by providing, posting, or otherwise making accessible) mailing addresses and telephone numbers (including toll-free hotline numbers where available) for local, State, or national victim advocacy or rape crisis organizations. The resident handbook has specific information for the residents to contact an outside advocate. The facility provides residents with access to such services by enabling reasonable communication between residents and these organizations in as confidential a manner as possible. The facility does not provide residents with access to such

	services by giving residents mailing addresses and telephone numbers (including toll-free hotline numbers where available) for immigrant services agencies for persons detained solely for civil immigration purposes; as they do not detain for civil immigration. Resident Handbook (English/Spanish). The resident handbook provides: You can speak with or send a note to any of the following: Ø Staff Member Ø Nurse Ø Your Probation Officer Ø Your Attorney Ø Your Parents/Legal Guardian Or you can make a report by: 1. Filing a grievance with the SAYS PREA Coordinator. 2. Calling the House of Ruth at 334-793-2232 or 1-800-650-6522 [AVAILABLE 24/7] 3. Calling the Southeast Alabama Child Advocacy Center at (334) 671-1779. ALL SAYS Facilities have a confidential process where counselors are notified that you need to speak with them. All facility staff members know what to do if you have been harmed and how to help you become safe (p.14). Resident Handbook brochure (English/Spanish): the resident handbook/brochure provides information to residents on information about sexual abuse and sexual harassment, an allegation will be investigated, how to avoid rape, what to do if you are sexually assaulted, how to make a report. PREA Pamphlet Sign Off (30). The Pamphlet provides information on what a sexual assault is, how to avoid Rape, the allegation will be investigated, and what to do if you are sexually assaulted. No Means No Poster (English/Spanish): the poster provides information on how to make a report, who to report to and access to victim advocacy and emotional support services. Site Review: During the site review, the auditor noted the following: Signage Clarity and Accessibility: During the review, the site added new signage detailing these services and how to access them by phone or mail.

	Signage is available in both English and Spanish, however not consistent throughout the facility. The size, format, and placement of the signage accommodates most readers, including those with low vision or physical disabilities. Signage is posted in key areas such as resident spaces, education areas, and housing units. Information is also included in the PREA handbook given to residents at intake. Signage is kept in good condition and is not obscured or damaged. Any damaged signage is promptly replaced. The signage contained information on how to make a report and who to make a report Accuracy and Consistency: The information on the signage, including phone numbers and mailing addresses, for outside reporting is accurate and consistent throughout the facility. Placement: Signage is strategically placed where it is accessible to residents, staff, and visitors. The auditor observed signage in administrative buildings, housing units, and educational areas. Informal Conversations: With Staff and Residents: Conversations confirmed that staff and residents are aware of the PREA posters and understand how to report incidents. It was also noted that staff and residents had limited knowledge about external victim advocacy and emotional support services. The facility has since implemented corrective actions to improve awareness and access to these services. Reporting via Phone: · Phone Access: Residents do not have unrestricted access to a phone. Instead, they must request permission from mental health staff to use the phone for external reporting. · Auditor's Test: The auditor assessed the external reporting method by calling the listed hotline as a resident would. The test confirmed the following: The staff phone that residents use to make a report is functional. The phone number on the signage connects directly to the external reporting entity. Reporting does not require the resident to provide their name; however, they must request phone access through staff, typically mental health staff. The hotline number is local/toll-free, answered by a live person, and available 24/7. The external reporting entity is equipped to receive reports of sexual abuse and harassment from residents and promptly forwards reports to agency officials. During the test, the auditor spoke with a representative who confirmed that residents can make reports and that the facility would be notified if pertinent information is provided. The reporting entity also confirmed that residents can report anonymously upon request. · Phone Call Privacy:

	While residents can access a phone through staff, informal conversations with staff indicated that when a resident requests to call the hotline, staff allow for confidentiality by stepping away, though they maintain a line of sight for supervision. · Monitoring Other Calls: Calls to parents and individuals on the approved list are monitored. Informal conversations with staff confirmed that phone calls are monitored to ensure compliance with the approved contact list. However, if a resident requests to call the hotline, staff will dial the number and then provide some privacy by stepping away while maintaining visual supervision. Residents, during informal conversations, reported that while calls are generally monitored, they believe they could have a confidential conversation if needed. Testing Internal Reporting Methods for Confined Persons Written Reporting: o Residents can submit written reports by writing a letter to any staff member or by filing a grievance. Each housing unit has a DYS grievance box with forms available in both English and Spanish, ensuring residents have easy daily access to submit grievances. o Informal conversations with residents confirmed that they have access to writing materials and can either place their grievance in the box or submit a written statement under the door of the mental health staff. Electronic Reporting: o The facility does not currently offer electronic means for residents to report allegations of sexual abuse or harassment. Verbal Reporting: o During informal and formal conversations, residents reported that they can verbally report incidents to any staff member or the DYS advocate, and they feel comfortable approaching trusted staff privately. o Staff consistently reported that residents can verbally report allegations at any time, and if they receive a report, they notify their supervisor immediately and document the allegation without delay. Processes for Sending and Receiving Mail (Mail Drop Boxes/Mailroom) o Outgoing Mail: o The auditor observed that residents have ready access to paper and pencils for writing letters. The outgoing mail process is as follows: o Residents write a letter, place it in an envelope obtained from the mental health staff, who then deliver it to administrative staff.

	o Administrative staff verify that the letter is addressed to an approved authority. o The mail clerk confirmed that resident mail is not read before being sent. They simply place a stamp on the envelope and ensure the mail is sent. o Incoming Mail: o Incoming mail follows a similar process. The mail clerk verifies that it is from an approved party, and residents open their mail in front of staff, shaking the envelope to ensure nothing is concealed. o While the facility does not have a locked or secured mail drop box, all incoming and outgoing mail is logged, which the auditor observed. Mail access is managed by an administrative staff/mail clerk. Record Storage Risk Screening Process: o The risk screening and other assessment tools (e.g., DYS assessment, biopsychosocial evaluations, treatment plans) are securely stored in an electronic case management system, with access limited to clinical staff and facility directors. The electronic system is password protected. Access Control: o Informal conversations with staff confirmed that access to the case management system, particularly the assessments, is restricted to clinical staff and facility leadership only. Interviews Residents(s) in custody Interview Questionnaire: Out of the ten residents in custody that were interviewed, three stated that they were aware of counseling services outside the facility that specifically address issues related to sexual abuse. However, these residents indicated that if they required access to such services, they would approach the staff for assistance. While they could not provide much information on the services, the residents stated that there was information on the board. When questioned about whether the conversations with people from these services would be told to or listened to by someone else, the residents where not sure as they felt the staff had to help and could hear the phone calls. Overall, the residents were not sure if the calls could remain private. Residents who Reported a Sexual Abuse: There was one resident identified during the onsite audit that reported sexual harassment. The resident stated that he did not provide any mailing addresses or telephone numbers for outside services. Nor did the resident feel like he needed outside services. Child Advocacy Center- The auditor spoke to leadership at the advocacy center in reference to the relationship with the juvenile detention center. It was reported they would first check on the status of the youth, and they would be able to provide

	counseling for the juvenile and the family; along with goods assistance services if needed. Additionally, it was stated that emotional support and advocacy services would be available to assist the juvenile and family through the process and they have contracted services for the counseling services. They have not received any request for services from the facility in the last 12 months. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.353 (b). The facility shall 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the facility informs residents prior to giving them access to outside support services, the extent to which such communications will be monitored. It was also reported that the facility informs residents, prior to giving them access to outside support services, of the mandatory reporting rules governing privacy, confidentiality, and/or privilege that apply to disclosures of sexual abuse made to outside victim advocates, including any limits to confidentiality under relevant Federal, State, or local law. Such information can be found in the resident handbook. Policy 13.8.1 Protection for Sexual Abuse and Assault states that “Facilities shall inform juveniles, 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” (p. 10). Interviews Residents(s) in custody Interview Questionnaire: Out of the ten residents in custody that were interviewed, three stated that they were aware of counseling services outside the facility that specifically address issues related to sexual abuse. However, these residents indicated that if they required access to such services, they would approach the staff for assistance. While they could not provide much information on the services, the residents stated that there was information on the board. When questioned about whether the conversations with people from these services would be told to or listened to by someone else, the residents where not sure as they felt the staff had to help and could hear the phone calls. Overall, the residents were not sure if the calls could remain private.

	Residents who Reported Sexual Abuse: The resident stated that he didn’t need the services so he is not sure if he could communicate with outside services confidentially. Child Advocacy Center- The auditor spoke to leadership at the advocacy center in reference to the relationship with the juvenile detention center. It was reported they would first check on the status of the youth, and they would be able to provide counseling for the juvenile and the family; along with goods assistance services if needed. Additionally, it was stated that emotional support and advocacy services would be available to assist the juvenile and family through the process and they have contracted services for the counseling services. They have not received any request for services from the facility in the last 12 months. Corrective Actions: · Posters: The facilities updated the PREA posters adding note indicating limitations of confidentiality. The poster also indicated that a 3rd party would have to report if one threatens to harm self or others. Updates were made during the post onsite process. No further action is required. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.353 (c). The agency shall 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. The agency shall maintain copies of agreements or documentation showing attempts to enter into such agreements. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency or facility maintains a memorandum of understandings or other agency agreements with community service providers that are able to provide residents with emotional support services related to sexual abuse. MOU Southeast Alabama Child Advocacy Center (CAC) provides guidance on access to outside emotional support services that are provided through the CAC. More specifically the MOU states the CAC provides victim advocacy and emotional support services related to sexual abuse. MOU House of Ruth provides guidance that the House of Ruth will provide follow-up services, referral, and crisis intervention contacts to victims of sexual assault and SAYS. Email correspondence with the victim advocacy center confirmed that the victim advocacy center identified by the agency contract can provide victim advocacy and

	emotional supportive services for residents at the program. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.353 (d). The facility should also provide residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the facility provides residents with reasonable and confidential access to their attorneys or other legal representation, and parents or legal guardians. Policy 13.8.1 Protection for Sexual Abuse and Assault states that "Facilities shall also provide juveniles with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians" (p. 10). Interviews Director/PREA Compliance Manager: The residents are provided with meaningful and confidential access to their attorneys and other legal representation/parents/guardians. They can have calls/zooms with the legal representatives as requested however the calls are visually monitored by staff. Parents/legal guardians are allowed to visit the residents and residents have weekly phone calls based on their program level. Residents(s) in custody Interview Questionnaire: Seven of the interview residents reported that they could talk with the lawyer in private. The other residents interviewed reported being unsure or did not think they could. It should also be noted that most of the residents did not have an attorney so they were not aware of the process. All of the residents reported that they could talk to the family members that were on an approved list. The residents stated that they could have visitation and phone calls. Residents who Reported a Sexual Abuse: One resident was identified as reporting sexual harassment onsite. The resident stated that he doesn't have an attorney but if he needed one, he could probably talk to them privately. The resident also stated that he could talk to his parents but he has not yet. Corrective Actions: · Resident Education: During the site review, the auditor found that residents

	were not adequately informed about victim advocacy and emotional support services. Although there were postings on the walls, residents were unaware of the services available and how to access them. The facility will develop a plan to incorporate information about advocacy and emotional support services into the intake process and conduct a group session with current residents to educate them on these services. Additionally, the facility must provide documentation confirming that the group session occurred and that these services were integrated into the intake process. Corrective Action Taken: On 10/1/2024 the residents were provided with a group session on mandatory reporting, confidentiality, victim advocacy and emotional support services. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.354	**Third-party reporting**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Documents: · Policy: Prison Rape Elimination Act (PREA) · Pre-audit Questionnaire · Website: https://www.saysdothan.com/prea · Third Party Reporting Form (English/Spanish) Findings (By Provision): 115.354 (a). The agency shall establish a method to receive third-party reports of sexual abuse and sexual harassment and shall distribute publicly information on how to report sexual abuse and sexual harassment on behalf of a resident. Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment, and the agency/facility publicly distributes information on how to report resident sexual abuse or sexual harassment on behalf of residents. Third Party Reporting Form (English/Spanish): the form is available @ https://www.saysdothan.com/prea. Site Review: During the site review, the auditor noted the following: Signage Clarity and Accessibility: During the review, the site added new signage detailing these services and how to access them by phone or mail. Signage is available in both English and Spanish, however not consistent throughout the facility therefore additional signage was placed. The size, format, and placement of the signage accommodates most readers, including those with low vision or physical disabilities. Signage is posted in key areas such as resident spaces, education areas, and housing units. Information is also included in the PREA handbook given to residents at intake. Signage is kept in good condition and is not obscured or damaged. Any damaged signage is promptly replaced. The signage contained information on how to make a report and who to make a report Accuracy and Consistency: The information on the signage for external sources, including phone numbers and mailing addresses, is accurate and consistent throughout the facility. The site contact information needed to be updated. Placement: Signage is strategically placed where it is accessible to residents, staff, and visitors. The auditor observed signage in administrative buildings, housing units, and educational areas. Informal Conversations: With Staff and Residents: Conversations confirmed that staff and residents are aware of the PREA posters and understand how to report incidents. It was also noted that staff and residents had limited knowledge about external victim advocacy and emotional support services. The facility has since implemented corrective actions to improve awareness and access to these services. TESTING THIRD-PARTY REPORTING Testing the Third-Party Reporting Method: The auditor assessed the third-party reporting process using the method publicly available, such as through the agency or facility website.

	The method for third-party reporting posted on the website was confirmed to be easily accessible and understandable, and it is prominently featured on the agency's PREA site. A test report was submitted by the auditor, and an immediate response was received from the facility indicating that follow-up contact would be made regarding the report. The auditor received follow-up correspondence from the PREA coordinator confirming that the report had been acknowledged. Evidence was provided via email showing that the report was received by the facility. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.361	**Staff and agency reporting duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Policy 1.11.1 Monitoring and Reporting Abuse and Neglect b. Policy 1.29.3 SAYS Protection Against Retaliation c. 26.14.3 Mandatory Reporting Code of Alabama d. Policy 13.8.1 Protection from Sexual Abuse and Assault e. Investigations (5) 2. Interviews: a. Random sample of staff - 10

	b. Medical and mental health staff -1 c. Director d. PREA Compliance Manager Findings (By Provision): 115.361 (a). The agency shall require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency requires all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency. The agency requires all staff to report immediately and according to agency policy any retaliation against residents or staff who reported such an incident. The agency requires all staff to report immediately and according to agency policy any staff neglect or violation of responsibilities that may have contributed to an incident or retaliation. Policy 1.11.1 Monitoring and Reporting Abuse and Neglect states that “SAYS will immediately report to the appropriate law enforcement agency or to the Alabama Department of Human Resources, as applicable, all known or suspected abuse or neglect of a child under 18 years of age in its care and custody” (p.1). The policy further includes sexual abuse and sexual exploitation in the definition of child abuse. Policy 1.29.3 SAYS Protection Against Retaliation provides guidance to staff to report immediately any staff neglect or violation of responsibilities that may have contributed to retaliation (p.1). Policy 13.8.1 Protection from Sexual Abuse and Assault also states that “Any employee who is a witness to or has knowledge of any sexual abuse/assault/harassment shall be responsible to immediately report it to his/her supervisor or designee. An employee who knowingly fails to report sexual abuse/assault/harassment of a juvenile shall be subject to disciplinary action” (p. 2). Code of Alabama 26-14-3 provides the state mandatory reporting laws. Interviews: Random Sample of Staff - The interviewed staff report that the agency requires all

	staff to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in the facility; retaliation against residents or staff who reported such an incident; and any staff neglect or violation of responsibilities that have contributed to an incident or retaliation. It was further reported that such information would be reported to the Director, Supervisor, or PREA Coordinator. Reports are made immediately. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.361 (b). The agency shall also require all staff to comply with any applicable mandatory child abuse reporting laws. Compliance Determination: The facility has demonstrated compliance with provision of the standard because: As reported in the PAQ, the facility requires that all staff comply with any applicable mandatory child abuse reporting laws. Policy 1.11.1 Monitoring and Reporting Abuse and Neglect states that “SAYS will immediately report to the appropriate law enforcement agency or to the Alabama Department of Human Resources, as applicable, all known or suspected abuse or neglect of a child under 18 years of age in its care and custody” (p.1). The policy further includes sexual abuse and sexual exploitation in the definition of child abuse and refers to the state statute Section 26-14-3, Code of Alabama. Code of Alabama 26-14-3 provides the state mandatory reporting laws. Interviews Random Sample of Staff: Ten random staff interviews; indicated a clear understanding of the duty to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility; retaliation against residents(s) in custody or staff who reported such an incident; and any staff neglect or violation of responsibilities that may have contributed to an incident of retaliation immediately. The various ways staff indicated that they could make a report included, but were not limited to: · Report to supervisor /PREA Coordinator · Call the PREA Hotline · Complete an incident or grievance report Corrective Actions:

	N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.361 (c). Apart from reporting to designated supervisors or officials and designated State or local services agencies, staff shall be 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, apart from reporting to the designated supervisors or officials and designated State or local service agencies, agency policy prohibits staff from revealing any information related to a sexual abuse report to anyone other than to the extent necessary to make treatment, investigation, and other security and management decisions. Policy 13.8.1 Protection from Sexual Abuse and Assault also states that "Apart from reporting to designated Manager/Supervisor, special investigators, law enforcement and designated State agencies, staff are prohibited from revealing any information related to a sexual assault report to anyone other than to the extent necessary, as specified in agency policy, to make treatment, investigation, and other security and management decisions" (p. 7). Interviews Random Sample of Staff: As previously stated, the interviewed random sample of staff indicated a clear understanding of the duty to report the above-mentioned immediately. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.361 (d). Medical and mental health practitioners shall be 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. (2) Such practitioners shall be required to inform residents at the initiation of services of their duty to report and the limitations of confidentiality. Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

Incidents that were reported: there was one reviewed incident that was reported by the medical/mental health staff.

Interviews

Medical and Mental Health Staff: The staff interviewed reported that they are required to disclose limitation of confidentiality and they have a duty to report upon initiation of services. They are also 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. The residents are notified during intake and they sign a documentation of the disclosures and limitations. There was an incident were a resident was reported over horseplay behavior.

Corrective Actions:

115.361 (e). Upon receiving any allegation of sexual abuse, the facility head or his or her designee shall promptly report the allegation to the appropriate agency office and 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. If the alleged victim is under guardianship of the child welfare system, the report shall be made to the alleged victim's case worker instead of the parents or legal guardians. If a juvenile court retains jurisdiction over the alleged victim, the facility head or designee shall also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

There were no reported allegations of sexual abuse.

Interviews

Director/PREA Compliance Manager: The director reported that if the victim is under the guardianship of the child welfare system, whey will notify the social worker of any allegation of sexual abuse. Notifications ae made immediately. This same process of notification would occur if a juvenile court retained jurisdiction.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.361 (f). The facility shall report all allegations of sexual abuse and sexual

	harassment, including third-party and anonymous reports, to the facility's designated investigators. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Investigation Report (5). The auditor reviewed five allegations that were administratively investigated. Interviews Director: All allegations of sexual abuse and sexual harassment, to include third party reports are reported to the agency investigator/PREA Coordinator. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Upon completion of the medical interview the facility will be compliant with the standard.

115.362	**Agency protection duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Policy 13.8.1 Protection from Sexual Abuse and Assault b. First Responder Card 2. Interviews: a. Agency Head b. Director

	c. Random sample of staff - 10 Findings (By Provision): 115.362 (a). When an agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it should take immediate action to protect the resident. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, when the agency or facility learns that a resident is subject to a substantial risk of imminent sexual abuse, it takes immediate action to protect the resident. In the past 12 months, the number of times the agency or facility has determined that a resident was subject to a substantial risk of imminent sexual abuse: 0. Policy 13.8.1 Protection from Sexual Abuse and Assault states that “when an agency learns that a juvenile is subject to a substantial risk of imminent sexual abuse, if shall take immediate action to protect the resident” (p. 8) Interviews Agency Head: The interviewed agency head reported that facility protocol related to “special conditions” would be implemented. The following procedure would be used: PROCEDURES A. Any SAYS employee, contract employee, employee of a SAYS contract provider, or volunteer that acquires knowledge of child abuse or neglect shall immediately report that knowledge to the facility administrator or appropriate designee. B. Upon notification, the facility administrator shall immediately notify SAYS PREA Coordinator. C. The PREA Coordinator will make the determination to contact the appropriate agency pursuant to applicable state law and SAYS policy. D. SAYS personnel shall cooperate with law enforcement and/or DHR investigators for the purpose of investigating allegations. The SAYS PREA Coordinator shall coordinate such cooperation to facilitate interviews of the alleged victim, alleged perpetrator, witnesses, and other legitimate investigation activities in connection with reports pursuant to SAYS policy. E. All reportable incidents must be reported in accordance with the Code of Alabama, 1975, as amended. Employees must also comply with all other SAYS policies regarding reporting incidents and critical incidents. Director: If there is an instance where a resident is subject to a substantial risk of imminent sexual abuse immediate protective measures would take place. Such

	actions would include immediately separating the parties involved, staff would be suspended while the investigation was going on, and if it involves a visitor/volunteer the person would be banned from the facility pending the investigation. Random Sample of Staff: The ten interviewed staff reported being aware of the agency procedure for reporting any information related to an individual in custody who may be at imminent risk of sexual abuse or sexual harassment. All staff interviewed would immediately notify the supervisor, separate the residents, and make sure the area is secure. Corrective Actions: · Policy: Policy did not reflect the language as provided in the provision. Corrective Action Implemented: The policy was updated to reflect the requirements of the provision. No further action is required. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.363	**Reporting to other confinement facilities**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Policy 13.8.1 Protection from Sexual Abuse and Assault b. Reporting to Other Confinement Facilities (blank) 2. Interviews: a. Agency head

b. Director

115.363 (a). Upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the agency where the alleged abuse occurred and shall also notify the appropriate investigative agency

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ the agency has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. In the past 12 months, the number of allegations the facility received that a resident was abused while confined at another facility: 0.

Policy 13.8.1 Protection from Sexual Abuse and Assault states that "Upon receiving an allegation that a juvenile was sexually abused while confined at another facility, the head of the facility that received the allegation shall notify the head of the facility or appropriate office of the facility where the alleged abuse occurred and shall also notify the appropriate investigative agency, using SAYS Form 115.363 Reporting to Other Confinement Facilities" (p. 8).

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.363 (b). Such notification should be provided as soon as possible, but no later than 72 hours after receiving the allegation.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

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

Policy 13.8.1 Protection from Sexual Abuse and Assault states that the FACILITY program policy requires that the facility head provides such notification as soon as possible, but no later than 72 hours after receiving the allegation (p. 8).

Corrective Actions:

	N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.363 (c). The agency shall document that it has provided such notification. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Policy 13.8.1 Protection from Sexual Abuse and Assault states that "Such notification shall be provided and documented as soon as possible, but no later than 72 hours after receiving the allegation" (p. 8). Form Reporting to Other Confinement Facilities (blank): the form provides a process for the facility to report and document said allegations. Corrective Actions: N/A. There are no corrective actions for this provision. 115.363 (d). The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency or facility requires that all allegations received from other agencies or facilities are investigated in accordance with the PREA standards. In the past 12 months, the number of allegations of sexual abuse the facility received from other facilities: 0. Policy 13.8.1 Protection from Sexual Abuse and Assault states that ""The facility administrator that receives such notification shall ensure that the allegation is investigated in accordance with PREA standards" (p. 8). Interviews Agency Head: The interviewed staff reported that if another agency or facility within your agency refers allegations of sexual abuse or sexual harassment that occurred within one of the facilities, per PREA policy and PREA Investigation Manual: The Executive Director/Clinical Services Coordinator/Therapist/Director of Facility is notified. At this time there are no examples of such allegations being reported from another facility or agency. Director: If there is an allegation from another facility or agency the allegation will be investigated immediately. There are no examples of such allegations made.

	Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.364	**Staff first responder duties**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy 13.8.1 Protection from Sexual Abuse and Assault c. First Responder Card 2. Interviews: a. Random sample of staff/Security Staff First Responders- 10 b. Non-Security Staff First Responders (1) c. Resident who Reported Sexual Abuse 115.364. (a). 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 occurred within a time period that still allows for the collection of physical evidence, request that the alleged victim not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating; and (4) If the abuse occurred within a time period that still allows for the collection of physical evidence, ensure that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

	Per the PAQ, there was one allegation of sexual abuse reported in the last 12 months. It should be noted that it was later determined that the allegation involved an incident at another facility. In the past 12 months, the number of allegations that a resident was sexually abused: 0. Of these allegations, the number of times the first security staff member to respond to the report separated the alleged victim and abuser: 0. In the past 12 months, the number of allegations where staff were notified within a time period that still allowed for the collection of physical evidence: 0. Of these allegations in the past 12 months where staff were notified within a time period that still allowed for the collection of physical evidence, the number of times the first security staff member to respond to the report preserved and protected any crime scene until appropriate steps could be taken to collect any evidence: 0. Of these allegations in the past 12 months where staff were notified within a time period that still allowed for the collection of physical evidence, the number of times the first security staff member to respond to the report requested 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: 0. Of these allegations in the past 12 months where staff were notified within a time period that still allowed for the collection of physical evidence, the number of times the first security staff member to respond to the report ensured 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: 0. Policy 13.8.1 Protection from Sexual Abuse and Assault (p. 8) states that: · Upon learning of an allegation that a juvenile was sexually abused, the first staff member to respond to the report shall be required to: · Separate the alleged victim and abuser. · Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence. · If the abuse occurred within a time period that 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. · 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 their supervisor. Refer to SAYS Form 115.364 First Responder Checklist and SAYS Form 115.364.1 First Responder Guidelines for Sexual Assault. · Staff shall follow SAYS Policy 115.371 Process for Investigating an Allegation of · Sexual Assault and refer to SAYS policy 1.29, SAYS Policy 1.29.1, SAYS Policy 1.29.2, and SAYS Policy 1.29.3 to ensure that SAYS and facility procedures are

	followed. · The staff First Responder Card provide step by step guidance on the process. Interviews Random Sample of Staff: Ten random staff interviewed reported being aware of the agency procedure for reporting any information related to an individual in custody who may be at imminent risk of sexual abuse or sexual harassment. All staff interviewed would immediately notify the supervisor, separate the residents, and make sure the area is secure. The staff were not consistently able to articulate the agency's process on how evidence is managed. Residents who Reported a Sexual Abuse: One resident onsite was identified as reporting sexual harassmtne.t The resident stated that it was reported two-three days ago to the therapist. He stated that staff came and spoke with him immediately. In addition, the staff separated him from the other resident. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.364 (b). If the first staff responder is not a security staff member, the responder shall be required to request that the alleged victim not take any actions that could destroy physical evidence, and then notify security staff. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ all staff members are considered first responders. Agency policy requires that if the first staff responder is not a security staff member, that responder shall be required to notify security staff. Of the allegations that a resident was sexually abused made in the past 12 months, the number of times a non-security staff member was the first responder: 0. Of those allegations responded to first by a non-security staff member, the number of times that staff member requested that the alleged victim not take any actions that could destroy physical evidence: 0. Of those allegations responded to first by a non-security staff member, the number of times that staff member notified security staff: 0. Policy 13.8.1 Protection from Sexual Abuse and Assault (p. 8), provides guidance on the above areas. Interviews Random Sample of Staff: Ten random staff interviewed reported being aware of the agency procedure for reporting any information related to an individual in custody

who may be at imminent risk of sexual abuse or sexual harassment. All staff interviewed would immediately notify the supervisor, separate the residents, and make sure the area is secure. The staff were not consistently able to articulate the agency's process on how evidence is managed.

Non-Security Staff First Responders: The interviewed staff were able to articulate the facility process to respond to an incident of sexual abuse. The staff reported that they would first separate the parties involved; wouldn't let them go to the bathroom, shower or anything needed to preserve evidence. We would obtain a statement and contact the PREA Coordinator. When probed, it was also reported that medical services would be contacted immediately to determine if hospital care was needed.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

Overall Findings:

The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.365 Coordinated response

Auditor Overall Determination: Meets Standard

Auditor Discussion

The following evidence was analyzed in making compliance determination:

1. Documents:

a. Pre-Audit Questionnaire (PAQ)

b. Written Institutional Plan

2. Interviews:

a. Director

Findings (By Provision):

115.365 (a). The facility shall develop 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the facility developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse. The Written Institutional Plan provides the agency with coordinated response. Interviews Director: All staff are trained in their roles as it relates to responding to an incident of sexual abuse. The staff are aware that the incident will be investigated, and the investigator will gather all documentation and coordinate with other agencies if needed. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.366	**Preservation of ability to protect residents from contact with abusers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	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). Neither the agency nor any other governmental entity responsible for collective bargaining on the agency's behalf shall enter into or renew any collective bargaining agreement or other agreement that limits the agency's ability to remove alleged staff sexual abusers from contact with residents pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: N/A-As reported in the PAQ, the agency, facility, or any other government entity responsible for collective bargaining on the agency's behalf has entered into or renewed any collective bargaining agreement or other agreement since August 20, 2012, or since the last PREA audit, whichever is later. Interviews Agency Head: The interviewed agency head reported that the agency is not responsible for collective bargaining. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.366 (b). Auditor is not required to audit this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.367	**Agency protection against retaliation**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion

The following evidence was analyzed in making compliance determination:

1. Documents:

a. Pre-Audit Questionnaire (PAQ)

b. Protection Against Retaliation (1)

c. Protection Against Retaliation Blank

2. Interviews:

a. Agency head

b. Director

c. Designated staff member charged with monitoring retaliation

d. Resident who Reported Sexual Abuse

Findings (By Provision):

115.367 (a). The agency shall establish 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 and shall designate which staff members or departments are charged with monitoring retaliation.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the facility has a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff. The agency has a designated staff charged with monitoring retaliation.

Policy 1.29.3 Protection Against Retaliation provides guidance on the agency policy to protect all “juveniles and staff who report sexual abuse or sexual harassment or cooperates with sexual abuse or sexual harassment investigations from retaliation by other juveniles or staff” (p. 1).

The facility provided documentation on one allegation where monitoring for retaliation was conducted.

A blank copy of the monitoring for retaliation was provided.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined

	that the agency and facility are fully compliant with this provision. 115.367 (b). The agency shall 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Protection Against Retaliation (1): the form was completed on an incident. The completed form shows the different measures that were taken after an allegation. Interviews Agency Head: The interviewed agency head reported that they would protect residents and staff from retaliation for sexual abuse or sexual harassment. Client can be moved to a different housing situation, depending on the circumstances and the client's level of comfort/need. If the alleged abuser is a fellow client, isolation from each other is maintained pending the outcome of the Investigation which may result in a more permanent solution. If staff, a leave of absence pending outcome of the investigation may take place. Counseling is provided by the client's therapist as needed to alleviate symptoms and maintain the safety of the client(s) involved. Director/Designated Staff Member Charged with Monitoring Retaliation (or Superintendent if non available): The interviewed staff reported that as the Director, part of my responsibility is to ensure that clients and staff do not retaliate against reporters of sexual abuse and sexual harassment. Some actions that could be taken include, room changes, separate involved parties, provide emotional support and follow up, remove abuser from the program, and weekly monitoring for retaliation for at least 13 weeks. Residents in Isolation (for risk of sexual victimization/who allege to have suffered sexual abuse) – There were no reported residents in isolation. Residents who Reported a Sexual Abuse – There were no identified residents who reported a sexual abuse. Resident who Reported a Sexual Abuse: There was one resident onsite that reported sexual harassment. The resident stated that he reported the incident to staff about two days ago and they responded immediately. He stated that he had not been given any other information, but the incident involved another resident. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined

that the agency and facility are fully compliant with this provision.

115.367 (c). For at least 90 days following a report of sexual abuse, the agency shall 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. Items the agency should monitor include any resident disciplinary reports, housing, or program changes, or negative performance reviews or reassignments of staff. The agency shall continue such monitoring for 90 days if the initial monitoring indicates a continuing need.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the agency/facility monitors the conduct or treatment of residents or staff who reported sexual abuse and of residents who were reported to have suffered sexual abuse to see if there are any changes that may suggest possible retaliation by residents or staff. It was further reported that the agency/ facility acts promptly to remedy any such retaliation; and the agency/facility continues such monitoring beyond 90 days if the initial monitoring indicates a continuing need. The number of times an incident of retaliation occurred in the past 12 months: 1.

Policy 1.29.3 Protection Against Retaliation provides guidance on the agency policy to protect all “juveniles and staff who report sexual abuse or sexual harassment or cooperates with sexual abuse or sexual harassment investigations from retaliation by other juveniles or staff” (p. 1). The policy provides full guidance on the process of monitoring and protecting retaliation.

Protection Against Retaliation (1): the form was completed on an incident. The completed form shows the different measures that were taken after an allegation.

Interviews

Director/Designated Staff Member Charged with Monitoring Retaliation (or Superintendent if non available): The interviewed staff reported that the monitoring would occur once a week for 13 weeks or until the victim was discharged from the program. During that time, we would look to see if there were changes with disciplinary reports, verbal reports, increased grievances. The staff would also talk to the resident to see what was going on and how they were doing.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

	115.367 (d). In the case of residents, such monitoring should also include periodic status checks. There were zero allegations of sexual abuse that occurred in the last 12 months. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Protection Against Retaliation (1): the form was completed on an incident. The completed form shows the different measures that were taken after an allegation. Interviews Director/Designated Staff Member Charged with Monitoring Retaliation (or Superintendent if non available): The interviewed staff reported that the monitoring would occur once per week for 13 weeks or until the victim left the program. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.367 (e). If any other individual who cooperates with an investigation expresses a fear of retaliation, the agency shall take appropriate measures to protect that individual against retaliation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Protection Against Retaliation (1): the form was completed on an incident. The completed form shows the different measures that were taken after an allegation. Interviews Agency Head: The interviewed agency head reported that they would protect residents and staff from retaliation for sexual abuse or sexual harassment. The facility would follow the following procedures: PROCEDURES 1. For at least 90 days following a report of sexual abuse, the facility shall monitor the conduct or treatment of juveniles or staff who reported the sexual abuse and of juveniles who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by juveniles or staff and shall act promptly to remedy any such retaliation. Monitoring shall be done using SAYS Form 115.367 Protection against Retaliation.

	2. Things the facility shall monitor include any juvenile disciplinary reports, unit/room changes, negative performance reviews or reassignments of staff. The facility shall continue such monitoring for 90 days if the initial monitoring indicates a continuing need. 3. In the case of juveniles, such monitoring shall also include periodic status checks, to determine if levels are lost for legitimate causes. 4. If any other individual who cooperates with an investigation expresses a fear of retaliation, the facility shall take appropriate measures to protect that individual against retaliation. 5. A facility's obligation to monitor shall terminate if it is determined that the allegation is unfounded. Director: The interviewed staff reported that as the Director, part of my responsibility is to ensure that clients and staff do not retaliate against reporters of sexual abuse and sexual harassment. Some actions that could be taken include, room changes, separate involved parties, provide emotional support and follow up, remove abuser from the program, and weekly monitoring for retaliation for at least 13 weeks. Additionally, immediate notification would occur with the PREA Coordinator, DYS, and Administration. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.367 (f). The auditor is not required to audit this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.368	**Post-allegation protective custody**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents:

	a. Pre-Audit Questionnaire (PAQ) b. Policy 13.8.1 Protection from Sexual Abuse and Assault 2. Interviews: a. Director b. Staff who supervise residents in isolation c. Medical and mental health staff- 1 Findings (By Provision): 115.368 (a). Any use of segregated housing to protect a resident who is alleged to have suffered sexual abuse shall be subject to the requirements of § 115.342. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the facility has a policy that residents who allege to have suffered sexual abuse may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all residents safe can be arranged. It was further reported that the facility policy requires that residents who are placed in isolation because they allege to have suffered sexual abuse have access to legally required educational programming, special education services, and daily large-muscle exercise. If a resident who is alleged to have suffered sexual abuse is held in isolation, the facility affords each such resident a review every 30 days to determine whether there is a continuing need for separation from the general population. The number of residents who alleged to have suffered sexual abuse who were placed in isolation in the past 12 months: 0. The number of residents who allege to have suffered sexual abuse who were placed in isolation who have been denied daily access to large muscle exercise, and/or legally required education or special education services in the past 12 months: 0. Policy 13.8.1 Protection from Sexual Abuse and Assault states that “Juveniles alleging sexual assault may be isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other juveniles safe, and then only until an alternative means of keeping all juveniles safe can be arranged. During any period of isolation, facilities shall not deny juveniles daily large-muscle exercise and any legally required educational programming or special education services. Juveniles in isolation shall receive daily visits from medical personnel or therapists. Juveniles shall also have access to other programs and work opportunities to the extent possible. Documentation of programming shall be maintained” (p. 6). Blank Visual Contact Monitoring Log

Interviews:

Director: The interviewed director reported that they have not had any instances of isolation due to sexual abuse allegation. Isolation is not utilized at the program.

Medical and Mental Health Staff: The staff interviewed reported that if a resident was in isolation, they would receive visits from medical staff as they are onsite. The psychologist is offsite. Services would be continued as needed.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

Overall Findings:

The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Upon completion of the medical interview the facility will be compliant with the standard.

115.371 Criminal and administrative agency investigations

Auditor Overall Determination: Meets Standard

Auditor Discussion

The following evidence was analyzed in making compliance determination:

1. Documents:

a. Pre-Audit Questionnaire (PAQ)

b. 1.29 Special Investigation Unit

c. 1.29.1 Referrals of Sexual Abuse Assault Harassment Allegations for Investigations

d. Investigations (5)

2. Interviews:

a. Investigative staff - 1

b. Director

	c. PREA coordinator d. PREA Compliance Manager e. Residents who Reported a Sexual Abuse 3. Corrective Action: a. Allegation Checklist Form b. PREA Investigations Findings Report c. Additional Investigator/Training Certification Findings (By Provision): 115.371 (a). When the agency conducts its own investigations into allegations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency/facility has a policy related to criminal and administrative agency investigations. Policy 1.29.1 Referrals of Sexual Abuse Assault Harassment Allegations for Investigations states that “when SAYS conducts its own investigations of sexual abuse and sexual harassment, it shall do so promptly, thoroughly, and objectively for all allegations, including third-party and anonymous reports” (p. 1). Interviews Investigative Staff: The interviewed staff reported that when an allegation of sexual abuse or sexual harassment is received the investigation is initiated immediately. All allegations to include anonymous or third party are managed in the same manner, with an immediate response. Corrective Actions: · Corrective Action Investigations: While the facility provided documentation of five allegations. Upon review all of the allegations were investigated as sexual harassment; however, one of the allegations should have been investigated as sexual abuse. Additionally, the documentation that is included in an investigation was not consistent and did not cover all of the elements such as including findings. Due to many staffing changes, there has been some insistence with the investigation process. The auditor is recommending that the agency develop a checklist of what items should be included in an administrative and a criminal investigation along with training another staff member to conduct investigations.

	Due Date: 11/15/2024. o Corrective Action Taken: the facility created an investigation checklist, PREA Investigations Findings Report forms. Additionally, documentation was provided where the PREA Coordinator was trained to serve as an investigator. 115.371 (b). Where sexual abuse is alleged, the agency shall use investigators who have received special training in sexual abuse investigations involving juvenile victims pursuant to § 115.334. Compliance Determination: Interviews Investigative Staff: The interviewed staff reported that they received training specific to conducting sexual abuse and sexual harassment investigations in confinement settings. The training included: techniques for interviewing juvenile sexual abuse victims, proper use of Miranda and Garrity warnings, Sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative or prosecution referral. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.371 (c). Investigators shall gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of sexual abuse involving the suspected perpetrator. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Investigation Record. (5) Interviews: Investigative Staff: The interviewed staff reported that first steps in initiating an investigation include: conducting interviews, notifying all necessary parties, reviewing video footage, write a report and conclusion, and notifying them of the outcome of the investigation. Direct or circumstantial evidence that would be gathered would include interviews, prior history of grievances/complaints, prior history of abuse, review rounds and staffing plans.

Corrective Actions:

· Corrective Action Investigations: While the facility provided documentation of five allegations. Upon review all of the allegations were investigated as sexual harassment; however, one of the allegations should have been investigated as sexual abuse. Additionally, the documentation that is included in an investigation was not consistent and did not cover all of the elements such as including findings. Due to many staffing changes, there has been some insistence with the investigation process. The auditor is recommending that the agency develop a checklist of what items should be included in an administrative and a criminal investigation along with training another staff member to conduct investigations. Due Date: 11/15/2024.

o Corrective Action Taken: the facility created an investigation checklist, PREA Investigations Findings Report forms. Additionally, documentation was provided where the PREA Coordinator was trained to serve as an investigator.

115.371 (d). The agency shall not terminate an investigation solely because the source of the allegation recants the allegation.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ the facility does not terminate an investigation solely because the source of the allegation recants the allegation.

Policy 1.29.1 Referrals of Sexual Abuse Assault Harassment Allegations for Investigations states that “SAYS shall not terminate an investigation solely because the source of the allegation recants the allegation” (p. 1).

Interviews

Investigative Staff: The staff interviewed reported that an investigation would not terminate if the source of the allegation recants their allegation. An investigation would still occur.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.371 (e). When the quality of evidence appears to support criminal prosecution, the agency shall conduct compelled interviews only after consulting with prosecutors as to whether compelled interviews may be an obstacle for subsequent criminal prosecution.

Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: Investigation Report (5) Interviews: Investigative Staff: The staff interviewed reported that they do not compel evidence. If a sexual assault occurred local law enforcement would investigate and determine any referrals for prosecution. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.371 (f). 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. No agency shall require a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding with the investigation of such an allegation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Interviews Investigative Staff: The investigator interviewed reported the credibility is based on their statements and the totality of the circumstances and ultimately what the evidence corroborates. Polygraphs are not given to the residents. Residents who Reported a Sexual Abuse: There was one resident onsite who reported sexual harassment. The resident stated that he was not required to take a polygraph test. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.371 (g). Administrative investigations: (1) Shall include an effort to determine whether staff actions or failures to act contributed to the abuse; and (2) 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.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Investigation (5): the facility provided documentation of five allegations that were administratively investigated. All of the investigations did not have a complete report. Site Review: RECORD STORAGE o The auditor observed the location of the physical storage of the PREA screenings and medical documentation. The documents were placed in a locked file cabinet in the nurse's station. The information is limited to the medical staff and to the site director. o The site uses paper instruments to complete PREA screenings and other intake medical related screenings. As previously discussed, the documents are held in a locked file cabinet in the nursing area. o There currently isn't a nurse onsite however the director who is also a nurse is filling in for that vacancy. The director provided the auditor with access to see where the files were stored. In addition, full resident files for current and prior residents are locked in an office in a locked storage cabinet. o Sexual abuse allegations are stored in a locked file cabinet in the director's office. Final copies are sent by the PREA Coordinator at the agency headquarters. Interviews Investigative Staff: The investigator interviewed reported that internal investigations are conducted when any misconduct allegations are reported. Investigations are documented in written reports. The reports will include statements made during interviews and review of video footage. Corrective Actions: · Investigations: While the facility provided documentation of five allegations. Upon review all of the allegations were investigated as sexual harassment; however, one of the allegations should have been investigated as sexual abuse. Additionally, the documentation that is included in an investigation was not consistent and did not cover all of the elements such as including findings. Due to many staffing changes, there has been some insistence with the investigation process. The auditor is recommending that the agency develop a checklist of what items should be included in an administrative and a criminal investigation along with training another staff member to conduct investigations. Due Date: 11/15/2024. o Corrective Action Taken: the facility created an investigation checklist, PREA Investigations Findings Report forms. Additionally, documentation was provided

	where the PREA Coordinator was trained to serve as an investigator. 115.371 (h). 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Investigation Report (5): Upon review there were no identified allegations that resulted in a criminal investigation. Interviews Investigative Staff: Criminal investigations are documented and contain receipt of all evidence gathered, photographs, audio and video recorded interviews, and written statements. Corrective Actions: Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.371 (i). Substantiated allegations of conduct that appears to be criminal shall be referred to for prosecution. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, there were zero substantiated allegations of conduct that appear to be criminal that were referred for prosecution since August 20,2012, or since the last PREA audit. The number of substantiated allegations of conduct that appear to be criminal that were referred for prosecution since August 20, 2012, or since the last PREA audit, whichever is later: 0. Investigation Report (5): Upon review of the reports there were no allegations that were referred to by criminal prosecution. Interviews Investigative Staff: The interviewed staff reported that cases are referred to in prosecution when an investigation reveals an allegation has been substantiated. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined

	that the agency and facility are fully compliant with this provision. 115.371 (j). The departure of the alleged abuser or victim from employment or control of the facility or agency shall not provide a basis for terminating an investigation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ the agency retains all written reports pertaining to administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.371 (k). The departure of the alleged abuser or victim from employment or control of the facility or agency shall not provide a basis for terminating an investigation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Interviews Investigative Staff: If a staff member alleges to have committed sexual abuse or sexual harassment terminates employes the investigation continues regardless of if her or she is still employed; and may be referred to local law enforcement. Corrective Actions: Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.371 (l). Auditor is not required to audit this provision. 115.371 (m). When outside agencies investigate sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation. Compliance Determination: The facility has demonstrated compliance with this provision of the standard

	because: Interviews Director: When an outside agency investigates, the facility would stay informed by having continued contact with the entity. The DHR has investigated incidents in the past and they provide weekly updates of the investigation. Once there is investigation is complete, they will notify them of the outcome of the investigation. PREA Coordinator - The interviewed PREA Coordinator reported that if an outside agency investigated allegations of sexual abuse we would communicate with the investigator. They will share the report of their findings with us. PREA Compliance Manager – The interviewed staff reported that if an outside agency investigates an allegation, they maintain contact with the investigator. They would communicate with the law enforcement and receive a report at the end of the investigation. Investigative Staff: If an outside agency conducts an investigation, they will assist in gathering information and serve as a liaison with the investigating agency. Corrective Actions: Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. The interim report indicated a need for corrective action to monitor the consistent compliance of the completion and thoroughness of an investigation. Following the corrective action period, the requested documentation was provided and assessed to be in alignment with the PREA standard. Additionally, during the audit period there were no PREA allegations to assess. Upon final review, the facility has been determined to be compliant.

115.372	**Evidentiary standard for administrative investigations**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents:

	a. Pre-Audit Questionnaire (PAQ) b. 1.29.1 Referrals of Sexual Abuse Assault Harassment Allegations for Investigations c. Investigations - 5 2. Interviews: a. Investigative staff – 1 3. Corrective Action: a. Investigation Checklist b. Investigation Training Findings (By Provision): 115.372 (a). The agency shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The facility reported in the PAQ, that the agency imposes a standard of a preponderance of the evidence or a lower standard of proof for determining whether allegations of sexual abuse or sexual harassment are substantiated. Policy 1.29.1 Referrals of Sexual Abuse Assault Harassment Allegations for Investigations states that “SAYS shall impose no standard higher than a preponderance of the evidence in determine whether allegations of sexual abuse or sexual harassment are substantiated” (p.2). Investigations (5): The reviewed investigations were not consistent. For the investigations that provided a narrative, the narrative was very detailed and informative. However, not all investigations included a narrative report. Interviews Investigative Staff: In general, the standard of evidence require substantiate allegations of sexual abuse or sexual harassment is beyond a reasonable doubt or preponderance of evidence. All outcomes are discussed with the PREA Coordinator. Corrective Actions: · Corrective Action Investigations: While the facility provided documentation of five allegations. Upon review all of the allegations were investigated as sexual harassment; however, one of the allegations should have been investigated as

	sexual abuse. Additionally, the documentation that is included in an investigation was not consistent and did not cover all of the elements such as including findings. Due to many staffing changes, there has been some insistence with the investigation process. The auditor is recommending that the agency develop a checklist of what items should be included in an administrative and a criminal investigation along with training another staff member to conduct investigations. Due Date: 11/15/2024. o Corrective Action Taken: the facility created an investigation checklist, PREA Investigations Findings Report forms. Additionally, documentation was provided where the PREA Coordinator was trained to serve as an investigator. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. The interim report indicated a need for corrective action to monitor the consistent compliance of the completion and thoroughness of an investigation. Following the corrective action period, the requested documentation was provided and assessed to be in alignment with the PREA standard. Upon final review, the facility has been determined to be compliant.

115.373	**Reporting to residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy 1.29.2 Reporting to Juveniles Following a Sexual Assault c. Juvenile Notification of Investigative Outcome (2) d. Investigations (5) 2. Interviews: a. Director b. Investigative staff – 1

c. Resident who Reported Sexual Abuse

Findings (By Provision):

115.373 (a). Following an investigation into a resident's allegation of sexual abuse suffered in an agency facility, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the agency has a policy requiring that any resident who makes an allegation that he or she suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency. The number of criminal and/or administrative investigations of alleged resident sexual abuse that were completed by the agency/facility in the past 12 months: 0. Of the alleged sexual abuse investigations that were completed in the past 12 months, the number of residents who were notified, verbally or in writing, of the results of the investigation: 0.

Policy 1.29.2 Reporting to Juveniles Following a Sexual Assault "following a juvenile's allegation that he or she has been sexually abused by another juvenile, the facility shall subsequently inform the alleged victim whenever:

o The facility learns that the alleged abuser has been indicated on a charge related to sexual abuse within the facility; or

o The facility learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility" (p. 1).

Notification of Investigation (2): two sexual harassment allegations were reviewed where notification was conducted to the resident.

Interviews

Director: Upon completion of the investigation, the victim is made aware of the outcome of the investigation.

Investigative Staff: The interviewed investigator reported that residents are notified of the results of the investigation. A copy of the outcome is reviewed with the resident to ensure they understand the information on the form. Residents are also informed that they have a right to appeal the findings through the grievance process.

Corrective Actions:

N/A. There are no corrective actions for this provision.

	Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.373 (b). If the agency did not conduct the investigation, it shall request the relevant information from the investigative agency in order to inform the resident. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, if an outside entity conducts such investigations, the agency requests the relevant information from the investigative entity in order to inform the resident of the outcome of the investigation. The number of investigations of alleged resident sexual abuse in the facility that were completed by an outside agency in the past 12 months: 0. Of the outside agency investigations of alleged sexual abuse that were completed in the past 12 months, the number of residents alleging sexual abuse in the facility who were notified verbally or in writing of the results of the investigation: 0. Investigation Report (5): All investigations reviewed were administratively investigated. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.373 (c). Following a resident's allegation that a staff member has committed sexual abuse against the resident, the agency shall subsequently inform the resident (unless the agency has determined that the allegation is unfounded) whenever: (1) The staff member is no longer posted within the resident's unit; (2) The staff member is no longer employed at the facility; (3) The agency learns that the staff member has been indicted on a charge related to sexual abuse within the facility; or (4) The agency learns that the staff member has been convicted on a charge related to sexual abuse within the facility. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The facility reported in the PAQ that following a resident’s allegation that a staff member has committed sexual abuse against the resident, the agency/facility subsequently informs the resident (unless the agency has determined that the allegation is unfounded) whenever: • The staff member is no longer posted within the resident’s unit; • The staff member is no longer employed at the facility; The agency learns that the staff member has been indicted on a charge related to

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

Policy 1.29.2 Reporting to Juveniles Following a Sexual Assault “following a juvenile’s allegation that he or she has been sexually abused by another juvenile, the facility shall subsequently inform the alleged victim whenever:

o The facility learns that the alleged abuser has been indicated on a charge related to sexual abuse within the facility; or

o The facility learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility” (p. 1).

o Notification (1)-Sexual Harassment allegation

Interviews:

Resident who Reported a Sexual Abuse: There was one resident onsite that reported sexual harassment. The resident stated that he reported the incident to staff about two days ago and they responded immediately. He stated that he had not been given any other information, but the incident involved another resident.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.373 (d). Following a resident's allegation that he or she has been sexually abused by another resident, the agency shall subsequently inform the alleged victim whenever: (1) The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or (2) The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

The facility reported in the PAQ that following a resident’s allegation that he or she has been sexually abused by another resident in an agency facility, the agency subsequently informs the alleged victim whenever: • The agency learns that the alleged abuser has been indicted on a charge related to sexual abuse within the facility; or • The agency learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility. There was one allegation made; however, the youth were no longer at the facility when the allegation was made; therefore, notification did not occur.

Policy 1.29.2 Reporting to Juveniles Following a Sexual Assault “following a juvenile’s

	allegation that he or she has been sexually abused by another juvenile, the facility shall subsequently inform the alleged victim whenever: o The facility learns that the alleged abuser has been indicated on a charge related to sexual abuse within the facility; or o The facility learns that the alleged abuser has been convicted on a charge related to sexual abuse within the facility” (p. 1). o Juvenile Notification Form (1) Interviews: Resident who Reported a Sexual Abuse: There was one resident onsite that reported sexual harassment. The resident stated that he reported the incident to staff about two days ago and they responded immediately. He stated that he had not been given any other information, but the incident involved another resident. Overall, the resident reported feeling safe at the facility. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.373 (e). All such notifications or attempted notifications shall be documented. Compliance Determination: The facility has demonstrated compliance with provision of this standard because: As reported in the PAQ, the facility has a policy that all notifications to residents described under this standard are documented. In the past 12 months, the number of notifications to residents that were provided pursuant to this standard: 0. Of those notifications made in the past 12 months, the number that were documented: 0 The FACILITY program has a policy that all notifications to residents described under this standard are documented. The facility updated its policy to state that “all victim notifications or attempted notifications shall be documented.” Juvenile Notification Form (2): The auditor reviewed two allegations of sexual harassment that received notification. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

	115.373 (f). The auditor is not required to audit this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and Residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.376	Disciplinary sanctions for staff
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy 13.8.1 Protection from Sexual Abuse and Assault Findings (By Provision): 115.376 (a). Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The facility 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 13.8.1 Protection from Sexual Abuse and Assault stated that “Staff shall be subject to disciplinary sanctions up to and including termination for violating SAYS sexual abuse or sexual harassment policies” (p. 12). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.376 (b). Termination shall be the presumptive disciplinary sanction for staff who

	have engaged in sexual abuse. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse. In the past 12 months, the number of staff from the facility who have violated agency sexual abuse or sexual harassment policies: 0. In the past 12 months, the number of staff from the facility who have been terminated (or resigned prior to termination) for violating agency sexual abuse or sexual harassment policies: 0. Policy 13.8.1 Protection from Sexual Abuse and Assault states that "Termination shall be the presumptive disciplinary sanction for staff who has engaged in sexual abuse" (p. 12). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.376 (c). Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: According to the PAQ, the disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) are commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories. In the past 12 months, the number of staff from the facility who have been disciplined, short of termination, for violation of agency sexual abuse or sexual harassment policies (other than actually engaging in sexual abuse): 0. Policy 13.8.1 Protection from Sexual Abuse and Assault states that "Disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment (other than actually engaging in sexual abuse) shall be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other

staff with similar histories” (p. 12).

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.376 (d). 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, unless the activity was clearly not criminal, and to any relevant licensing bodies.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

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

Policy 13.8.1 Protection from Sexual Abuse and Assault states 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, unless the activity was clearly not criminal, and to any relevant licensing bodies” (p. 12).

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

Overall Findings:

The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.377	Corrective action for contractors and volunteers
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy 13.8.1 Protection from Sexual Abuse and Assault 2. Interviews: a. Director Findings (By Provision): 115.377 (a). Any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with residents and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, there have been zero 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. In the past 12 months, the number of contractors or volunteers reported to law enforcement for engaging in sexual abuse of residents: 0. Policy 13.8.1 Protection from Sexual Abuse and Assault states that “any contractor or volunteer who engages in sexual abuse shall be prohibited from contact with juveniles and shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies” (p. 13). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.377 (b). The facility shall take appropriate remedial measures and shall consider whether to prohibit further contact with residents, in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or

	volunteer. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ the facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. Interviews Director: If a contractor or volunteer violated the sexual abuse and sexual harassment policy, measures would be taken. The person would not be allowed back into the facility. All staff would be immediately retrained for PREA as well as the resident. Additional training would address boundaries. Additionally, we would increase unannounced rounds and review camera footage. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.378	**Interventions and disciplinary sanctions for residents**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy 13.8.1 Protection from Sexual Abuse and Assault

c. Investigations (5)

d. Memorandum of Policy Directive

2. Interviews:

a. Director

b. Medical and mental health staff -1

Findings (By Provision):

115.378 (a). A resident may be subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that the resident engaged in resident-on-resident sexual abuse or following a criminal finding of guilt for resident-on-resident sexual abuse.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, there were no reported residents subject to disciplinary sanctions following an administrative finding that the resident engaged in resident-on-resident sexual abuse, following a criminal finding of guilt for resident-on-resident sexual abuse. In the past 12 months, the number of administrative findings of resident-on-resident sexual abuse that have occurred at the facility: 5. In the past 12 months, the number of criminal findings guilty of resident-on-resident sexual abuse that have occurred at the facility: 0.

Policy 13.8.1 Protection from Sexual Abuse and Assault states that “A juvenile may be subject to disciplinary sanctions by a Disciplinary Committee only pursuant to a formal disciplinary process following an administrative finding that the juvenile engaged in juvenile-on-juvenile sexual abuse or following a criminal finding of guilt for juvenile-on-juvenile sexual abuse” (p. 12).

Investigation Reports (5): upon review of the investigation there were no findings associated with sexual abuse.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.378 (b). Any disciplinary sanctions shall be commensurate with the nature and circumstances of the abuse committed, the residents’ disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories. In the event a disciplinary sanction results in the isolation of a resident, agencies shall not deny the resident daily large-muscle exercise or access to any legally

	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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: Per the PAQ, in the event a disciplinary sanction for resident-on resident sexual abuse results in the isolation of a resident, the facility policy requires that residents in isolation have daily access to large muscle exercise, legally required educational programming, and special education services. It was also reported in the PAQ that in the event a disciplinary sanction for resident-on-resident sexual abuse results in the isolation of a resident, residents in isolation have access to other programs and work opportunities to the extent possible. In the past 12 months, the number of residents placed in isolation as a disciplinary sanction for resident-on-resident sexual abuse: 0. In the past 12 months, the number of residents placed in isolation as a disciplinary sanction for resident-on-resident sexual abuse who were denied daily access to large muscle exercise, and/or legally required educational programming, or special education services: 0 In the past 12 months, the number of residents placed in isolation as a disciplinary sanction for resident-on-resident sexual abuse who were denied access to other programs and work opportunities: 0. Policy 13.8.1 Protection from Sexual Abuse and Assault states that "Any disciplinary sanctions shall be commensurate with the nature and circumstances of the abuse committed, the juvenile's disciplinary history, and the sanctions imposed for comparable offenses by other juveniles with similar histories. In the event a disciplinary sanction results in the isolation of a juvenile, facilities shall not deny the juvenile daily large• muscle exercise or access to any legally required educational programming or special education services. Juveniles in isolation shall receive daily visits from a medical or mental health care clinician. Juveniles shall also have access to other programs and work opportunities to the extent possible. Documentation will be made using SAYS Form 115.342. Isolation Activity Log" (p. 12). Investigation Reports (5): upon review of the investigation there were no findings associated with sexual abuse. Interviews Director: Disciplinary sanctions would include the youth receiving appropriate interventions based on treatment, counseling, and education. Such sanctions would be proportionate to the nature and circumstances of the abuse. Depending on the circumstance it may include loss of privileges, loss of level, loss of visitation, review

	of placement, and placement extension with DYS. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.378 (c). The disciplinary process shall consider whether a resident's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. The facility has demonstrated compliance with this provision of the standard because: Investigation Reports (5): upon review of the investigation there were no findings associated with sexual abuse. Interviews Director: Disciplinary sanctions would include the youth receiving appropriate interventions based on treatment, counseling, and education. Such sanctions would be proportionate to the nature and circumstances of the abuse. Depending on the circumstance it may include loss of privileges, loss of level, loss of visitation, review of placement, and placement extension with DYS. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.378 (d). If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to offer the offending resident participation in such interventions. The agency may require participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, but not as a condition to access to general programming or education. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the facility offers therapy, counseling, or other interventions designed to address and correct the underlying reasons or motivations for abuse. The facility provides access to general programming or education, as needed.

Policy 13.8.1 Protection from Sexual Abuse and Assault states that “If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to offer the offending juvenile participation in such interventions. The facility may require participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, but not as a condition to access to general programming or education” (p. 12).

Interviews

Medical and Mental Health Staff: The staff interviewed reported that therapy, counseling, or other intervention services are offered. If medical services are needed, they would be offered and addressed immediately. The resident is not required to participate in services as a part of the rewards behavior management system, programming, or education.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.378 (e). The agency may discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the facility disciplines resident sexual contact with staff only upon finding that the staff member did not consent to such contact.

Policy 13.8.1 Protection from Sexual Abuse and Assault states that “Facilities may discipline a juvenile for sexual contact with staff only upon a finding the staff member did not consent to such contact” (p. 12).

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.378 (f). For the purpose of disciplinary action, a report of sexual abuse 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.

Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the facility prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish sufficient evidence to substantiate the allegation. Policy 13.8.1 Protection from Sexual Abuse and Assault states that "For the purpose of disciplinary action, a report of sexual abuse 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" (pp. 12-13) Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.378 (g). An agency may, in its discretion, prohibit all sexual activity between residents and may discipline residents for such activity. An agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the facility prohibits sexual activity between residents. In addition, the agency prohibits all sexual activity between residents and disciplines residents for such activity, the agency deems such activity to constitute sexual abuse only if it determines that the activity is coerced. Policy 13.8.1 Protection from Sexual Abuse and Assault states that "SAYS prohibits all sexual activity between juveniles and may discipline juveniles for such activity. SAYS does not deem such activity to constitute sexual abuse if it determines that the activity is not coerced" (p. 13). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility,

	facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Upon completion of the medical interview the facility will be compliant with the standard.

115.381	**Medical and mental health screenings; history of sexual abuse**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy 13.8.1 Protection from Sexual Abuse and Assault c. Risk Screening (1) d. Follow Up Notes e. Copy of PRE-Screening Tracker 2. Interviews: a. Staff responsible for risk screening - 2 b. Medical staff -1 Findings (By Provision): 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, staff shall ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. Compliance Determination: The facility had demonstrated compliance with this provision of the standard because: As reported in the PAQ, residents at the facility who disclosed any prior sexual victimization during a screening pursuant to 115.341 are offered a follow-up meeting with a medical or mental health practitioner. Medical and mental health staff maintain secondary materials (e.g., form, log) documenting compliance with the above-mentioned services. In the past 12 months, the percentage of residents who disclosed prior victimization during screening were offered a follow-up meeting

	with a medical or mental health practitioner: 1. Policy 13.8.1 Protection from Sexual Abuse and Assault states that “In Residential placements i.e., Boys and Girls Attention Homes, Louisville Program, consultation with the Therapists or the Residential Manager shall incorporate appropriate treatment goals and objectives into the Med/Rehab Child Adolescent treatment plans to address any identified issues. If the screening indicates that a juvenile has experienced prior sexual victimization or has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff shall ensure that the juvenile is offered a follow up meeting with a medical or mental health practitioner within 14 days of the intake screening” (p. 5). Rescreening (1) and follow-up note were provided for one resident that reported a prior history of sexual abuse. Interviews Staff Responsible for Risk Screening: The interviewed staff responsible for risk screening reported that if a screening indicates that a resident has experienced prior sexual victimization, whether in an institutional setting or in the community, the clinical team will meet with the resident immediately or within 24 hours and document in the case notes. Residents(s) in custody who Disclose Sexual Victimization at Risk Screening: There were no identified residents during the onsite audit. Corrective Actions: Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 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, staff shall ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening. Compliance Determination: The facility had demonstrated compliance with this provision of the standard because: As indicated in the PAQ, all residents who have previously perpetrated sexual abuse are offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening. In the past 12 months, the percentage of residents who previously perpetuated sexual abuse, as indicated during screening, who were offered a follow up meeting with a mental health practitioner: Policy 13.8.1 Protection from Sexual Abuse and Assault states that “In Residential placements i.e., Boys and Girls Attention Homes, Louisville Program, consultation with the Therapists or the Residential Manager shall incorporate appropriate

	treatment goals and objectives into the Med/Rehab Child Adolescent treatment plans to address any identified issues. If the screening indicates that a juvenile has experienced prior sexual victimization or has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff shall ensure that the juvenile is offered a follow up meeting with a medical or mental health practitioner within 14 days of the intake screening" (p. 5). Rescreening (1) and follow-up note were provided for one resident that reported a prior history of sexual abuse. Interviews Staff Responsible for Risk Screening: The interviewed staff responsible for risk screening reported that if a screening indicates that a resident has experienced prior sexual perpetration, whether in an institutional setting or in the community, the clinical team will meet with the resident immediately or within 24 hours and document in the case notes. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.381 (c). Any information related to sexual victimization or abusiveness that occurred in an institutional setting shall be strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security and management decisions, including housing, bed, work, education, and program assignments, or as otherwise required by Federal, State, or local law. Compliance Determination: The facility had demonstrated compliance with this provision of the standard because: As reported in the PAQ, information related to sexual victimization or abusiveness that occurred in an institutional setting is strictly limited to medical and mental health practitioners. Policy 13.8.1 Protection from Sexual Abuse and Assault states that "Any information related to sexual abuse 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 unit/room placement, education, and program assignments. Refer to SAYS Form 115 .341.2 Guidelines for PREA Shared Information" (p. 5). Site Review: RECORD STORAGE During the site review, the auditor must:

	o The auditor observed the location of the physical storage of the PREA screenings and medical documentation. The documents were placed in a locked file cabinet in the nurse's station. The information is limited to the medical staff and to the site director. o The site uses paper instruments to complete PREA screenings and other intake medical related screenings. As previously discussed, the documents are held in a locked file cabinet in the nursing area. o There currently isn't a nurse onsite however the director who is also a nurse is filling in for that vacancy. The director provided the auditor with access to see where the files were stored. In addition, full resident files for current and prior residents are locked in an office in a locked storage cabinet. o Sexual abuse allegations are stored in a locked file cabinet in the director's office. Final copies are sent by the PREA Coordinator at the agency headquarters. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.381 (d). Medical and mental health practitioners shall 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. Compliance Determination: The facility had demonstrated compliance with this provision of the standard because: As reported in the PAQ, medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18. Policy 13.8.1 Protection from Sexual Abuse and Assault states that "Medical and mental health practitioners shall obtain informed consent from juveniles before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the juvenile is under the age of 18, using SAYS Form 100.8 Informed Consent for documentation. Interviews Medical and Mental Health Staff: Prior to reporting sexual abuse, the medical staff will speak to the resident. Residents are notified of the informed consent process at intake. The guardians are also notified. Corrective Actions:

	N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Upon completion of the medical interview the facility will be compliant with the standard.

115.382	**Access to emergency medical and mental health services**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy 13.8.1 Protection from Sexual Abuse and Assault c. Genesis House 2. Interviews: a. Medical and mental health staff -1 b. Security staff and non-security staff first responders (4) Findings (By Provision): 115.382 (a). Resident victims of sexual abuse shall 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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. Medical and mental health staff do not maintain secondary materials (e.g., form, log) documenting the timeliness of emergency medical treatment and crisis intervention services that were provided; the appropriate response by non-health staff in the event health staff are not present at the time the incident is reported; and the provision of appropriate and timely information and services concerning contraception and sexually transmitted infection prophylaxis. Policy 13.8.1 states that "SAYS shall offer medical and mental health evaluation and, as appropriate, treatment to all juveniles who have been victimized by sexual abuse in any juvenile facility" (p 10). Interviews Medical and Mental Health Staff: If a resident reports sexual abuse they receive timely and unimpeded access to emergency medical treatment and/or crisis intervention services. This is done immediately, and the staff will notify the supervisor immediately. The nature and scope of such services are determined according to professional judgment. Resident who Reported Sexual Abuse: The interviewed resident did not report sexual abuse. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.382 (b). If no qualified medical or mental health practitioners are on duty at the time a report of recent abuse is made, staff first responders shall take preliminary steps to protect the victim pursuant to § 115.362 and shall immediately notify the appropriate medical and mental health practitioners. Compliance Determination: The facility had demonstrated compliance with this provision of the standard because: There were no identified allegations of sexual abuse. Interviews Random Sample of Staff: Ten random staff interviewed reported being aware of the agency procedure for reporting any information related to an individual in custody who may be at imminent risk of sexual abuse or sexual harassment. All staff interviewed would immediately notify the supervisor, separate the residents, and make sure the area is secure. The staff were not consistently able to articulate the agency's process on how evidence is managed.

	Compliance Determination: The facility had demonstrated compliance with this provision of the standard because: Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.382 (c). Resident victims of sexual abuse while incarcerated shall be offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Compliance Determination: The facility had demonstrated compliance with this provision of the standard because: 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. I interviewed medical and mental health staff reported that such services are addressed immediately. Interviews Medical and Mental Health Staff: The interviewed staff reported that victims of sexual abuse are offered timely information about access to emergency contraception and sexual transmitted infection prophylaxis. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.382 (d). Treatment services shall be 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the treatment services provided to every victim are without financial cost and regardless of whether the victim names the abuser or cooperates

	with any investigation arising out the incident. Policy 13.8.1 Protection from Sexual Abuse and Assault states that “Treatment services shall be 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” (p. 11). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Upon completion of the medical interview the facility will be compliant with the standard.

115.383	**Ongoing medical and mental health care for sexual abuse victims and abusers**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: 1. Documents: a. Pre-Audit Questionnaire (PAQ) b. Policy 13.8.1 Protection from Sexual Abuse and Assault c. Genesis House MOU d. Youth Villages MOU 2. Interviews: a. Medical and Mental Health staff -1 Findings (By Provision): 115.383 (a). The facility shall 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.

	Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the facility offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. Policy 13.8.1 Protection from Sexual Abuse and Assault states that "SAYS shall offer medical and mental health evaluation and, as appropriate, treatment to all juveniles who have been victimized by sexual abuse in any juvenile facility" (p. 11). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 185.383 (b). The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: There were no residents identified as being sexually abused. Interviews Medical and Mental Health Staff: The interviewed staff reported that evaluation and treatment of residents who have been victimized entails the patient being evaluated by medical staff, supervisor of facility is informed of concern and patient is sent out for follow-up treatment with the legal guardian for external treatment and follow up care. Corrective Actions: Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.383 (c). The facility shall provide such victims with medical and mental health services consistent with the community level of care. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

There were no residents identified as being sexually abused.

Interviews

Medical and Mental Health Staff: The staff interviewed reported that medical treatment and services is consistent with the community level of care.

Corrective Actions:

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.383 (d). Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

- The site does not house female residents.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.383 (e). Resident victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests.

Compliance Determination:

The facility had demonstrated compliance with this provision of the standard because:

- The site does not house female residents.

Interviews

Medical and Mental Health Staff: There are no female residents at the site.

Corrective Actions:

Pending Medical Interview. The interview was conducted, and no further action is needed.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.383 (f). Resident victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate.

Compliance Determination:

The facility had demonstrated compliance with this provision of the standard because:

As reported in the PAQ, resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate.

Policy 13.8.1 Protection from Sexual Abuse and Assault states that “Juvenile victims of sexual abuse while incarcerated shall be offered tests for sexually transmitted infections as medically appropriate” (p. 11).

Interviews

Residents who reported sexual abuse: There are no resident identified who reported sexual abuse.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.383 (g). Treatment services shall be 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.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

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

Policy 13.8.1 Protection from Sexual Abuse and Assault states that “Treatment services shall be 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” (p. 11).

Interviews

There were no residents identified as being sexually abused.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.383 (h). The facility shall 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.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the facility attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate by mental health practitioners. Upon admission all juveniles will receive a mental health assessment by a professional mental health provider for the purpose of identifying suicidal tendencies, sexual abuse victimization and predatory risk to other residents.

Policy 13.8.1 Protection from Sexual Abuse and Assault states that “SAYS shall attempt to conduct a mental health evaluation of all known juvenile-on-juvenile abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners” (p. 11).

Interviews

Medical and Mental Health Staff: A mental health evaluation is conducted on all known resident on resident abusers and treatment is offered as needed.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

Overall Findings:

The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Upon completion of the medical interview the facility will be compliant with the standard.

115.386 Sexual abuse incident reviews

Auditor Overall Determination: Meets Standard

Auditor Discussion

The following evidence was analyzed in making compliance determination:

1. Documents:

a. Pre-Audit Questionnaire (PAQ)

b. Policy 13.8.1 Protection from Resident Sexual Abuse and Assault

c. Sexual Abuse Critical Incident Review- (1)

2. Interviews:

a. Director

b. Incident review team

c. PREA Compliance Manager

Findings (By Provision):

115.386 (a). The facility shall 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.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the facility 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. The facility provided a document that shows how an incident review debriefing would be documented. In the past 12 months, the number of criminal and/or administrative investigations of alleged sexual abuse completed at the facility, excluding only "unfounded" incidents: 5.

Policy 13.8.1 Protection from Sexual Abuse states that “The facility PREA Coordinator shall conduct a sexual abuse incident review using SAYS Form 115.386 Sexual Abuse Critical 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” (p. 13).

Critical Incident Review: while the facility uploaded several investigations there was only one incident review uploaded, and it was for a substantiated sexual harassment allegation.

Corrective Actions:

N/A. There are no corrective actions for this provision

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.386 (b). Such review shall ordinarily occur within 30 days of the conclusion of the investigation.

Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: The facility ordinarily conducts a sexual abuse incident review within 30 days of the conclusion of the criminal or administrative sexual abuse investigation. In the past 12 months, the number of criminal and/or administrative investigations of alleged sexual abuse completed at the facility were followed by a sexual abuse incident review within 30 days, excluding only "unfounded" incidents: 0. Critical Incident Review: while the facility uploaded several investigations there was only one incident review uploaded and it was for a substantiated sexual harassment allegation. Interviews: PREA Compliance Manager: The interviewed staff reported that the incident reviews are conducted and the PREA Compliance Manager is a part of the review. The facility has not had sexual abuse allegation. Incident Review Team: The interviewed staff on the incident review team reported that the team will 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 at the facility. Overall, we will look to see what motivated the incident. Corrective Actions: N/A. There are no corrective actions for this provision Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.386 (c). The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: 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. Policy 13.8.1 Protection from Sexual Abuse and Assault states that “The review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or therapists” (p. 13). Critical Incident Review: while the facility uploaded several investigations there was

only one incident review uploaded, and it was for a substantiated sexual harassment allegation.

Interviews:

Director: The team does an incident review, and all allegations. This is also done with the treatment team. Members of the team are asked to input.

Corrective Actions:

N/A. There are no corrective actions for this provision

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.386 (d). 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; or gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility; (3) Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse; (4) Assess the adequacy of staffing 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 pursuant to paragraphs (d)(1)-(d)(5) of this section, and any recommendations for improvement and submit such report to the facility head and PREA compliance manager.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the facility prepares a report of its findings from sexual abuse incident reviews, including but not necessarily limited to determinations made pursuant to paragraphs (d)(1) -(d)(5) of this section and any recommendations for improvement, and submits such report to the facility head and PREA Compliance Manager.

Sexual Abuse Critical Incident Review Form. The form takes the following into consideration:

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. Determine whether the facility implemented the recommendation for improvement. Interviews: Directo/PREA Compliance Manager: The team does an incident review, an all allegations. This is also done with the treatment team. Members of the team are asked to input. The team will use the information to check for policy deviation or need for policy change, train staff, and to protect residents from similar issues. All of the above-mentioned areas are considered in the review process and changes would be made if deemed necessary. Incident Review Team: The interviewed staff on the incident review team reported that the team will 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 at the facility. Furthermore, the team will examine the area in which the incident took place and see if there is an issue with staffing or are incidents typically happening at the same location or with the same staff. This may be an opportunity to retrain staff if needed. Corrective Action N/A. There are no corrective actions for this provision Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.386 (e). The facility shall implement the recommendations for improvement or shall document its reasons for not doing so. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: The facility reported in the PAQ that the facility implements recommendations for improvement or documents its reasons for not doing so. Critical Incident Review: while the facility uploaded several investigations there was only one incident review uploaded, and it was for a sexual harassment allegation.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

Overall Findings:

The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.387 Data collection

Auditor Overall Determination: Meets Standard

Auditor Discussion

The following evidence was analyzed in making compliance determination:

1. Documents:

a. Pre-Audit Questionnaire (PAQ)

b. Policy 13.8.1 Protection from Sexual Abuse and Assault

c. PREA Data Report Comparison

Findings (By Provision):

115.387 (a). The agency shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the agency collects accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions.

Policy 13.8.1 states that “SAYS shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using the DOJ Form SSV-IJ Survey of Sexual Violence Incident Report, standardized instrument and

definitions” (p. 13).

PREA Data Report Comparison provides an overview of allegations reported.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.387 (b). The agency shall aggregate the incident-based sexual abuse data at least annually.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the agency aggregates incident-based sexual abuse data annually.

PREA Data Report Comparison provides an overview of allegations reported.

Corrective Actions:

N/A. There are no corrective actions for this provision.

115.387 (c). The incident-based data collected shall include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the facility uses a standardized instrument includes, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence (SSV) conducted by the Department of Justice.

Policy 13.8.1 Protection from Sexual Abuse and Assault states that “SAYS and private providers shall aggregate the incident-based sexual abuse data at least annually using SAYS Form 115.387 PREA Data Report” (p. 13).

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.387 (d). The agency shall maintain, review, and collect data as needed from all

available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. Policy: Prison Rape Elimination Act (PREA), (pg. 19), states that "the agency shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews.

Policy 13.8.1 Protection from Sexual Abuse and Assault states that "Facilities shall maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews" (p. 14).

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.387 (e.) N/A the agency does not contract for the confinement of its residents and skips to 115.387 (f).). It was further reported that the data from private facilities complies with SSV reporting regarding content.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

The agency does not contract with other private facilities for the confinement of its Residents.

Corrective Actions:

N/A. There are no corrective actions for this provision.

115.387 (f). Upon request, the agency shall provide all such data from the previous calendar year to the Department of Justice no later than June 30.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the agency has not been required to provide the

Department of Justice (DOJ) with data from the previous calendar year.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

Overall Findings:

The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.388 Data review for corrective action

Auditor Overall Determination: Meets Standard

Auditor Discussion

The following evidence was analyzed in making compliance determination:

1. Documents:

a. Pre-Audit Questionnaire (PAQ)

b. Policy: Prison Rape Elimination Act (PREA)

c. PREA Data Report Comparison

d. Staffing Plan

e. Website: https://static1.squarespace.com/static/598b3628197aea4997aafcfb/t/661d88db102fad5a6f89a545/1713211611368/115.387+PREA+Data+Report+-+Comparison.pdf

2. Interviews:

a. Agency head

b. PREA coordinator

c. PREA Compliance Manager

Findings (By Provision):

115.388 (a). The agency shall 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: (1) Identifying problem areas; (2) Taking corrective action on an ongoing basis; and (3) Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the agency reviews data collected and aggregated pursuant 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training, including:

- Identified problem areas;

- Taking corrective action on an ongoing basis; and

- Preparing an annual report of its findings from its data review and corrective actions for each facility, as well as the agency as a whole.

- Policy: Prison Rape Elimination Act (PREA), (pg. 19), states that "the Agency PREA Coordinator will review, analyze, and use all sexual abuse data, including incident-based and aggregated data, to assess and improve the effectiveness of the agency sexual abuse prevention, detection, and response policies, practices, and training".

PREA Data Report Comparison provides an overview of allegations reported.

Interviews

Agency Head: The interviewed agency head reported that incident based sexual abuse data is used to assess and improve problem areas or other issues are identified and corrective action is taken as needed. We have had no incidents to date but are constantly analyzing how we can improve things. Training is ongoing and required for all staff.

PREA Coordinator: The interviewed PREA Coordinator reported that all data is completed, and that a plan of action would be created to address any corrective actions.

PREA Compliance Manager: The interviewed staff reported that data is collected, and reports made along with the annual reports are kept with the PREA Coordinator.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined

that the agency and facility are fully compliant with this provision.

115.388 (b). Such report should include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the agency's progress in addressing sexual abuse.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the annual report indicates a comparison of the current year’s data and corrective actions to those from prior years. The annual report provides an assessment of the agency's progress in addressing sexual abuse.

PREA Data Report Comparison provides an overview of allegations reported.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.388 (c). The agency's report shall be 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.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

As reported in the PAQ, the agency makes its annual report readily available to the public, at least annually, through its website. The agency PREA reports are found at https://static1.squarespace.com/static/598b3628197aea4997aafcfb/t/661d88db102fad5a6f89a545/1713211611368/115.387+PREA+Data+Report+-+Comparison.pdf

Interviews

Agency Head: The agency head interviewed reported that they approve the agency annual reports.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.388 (d). The agency may redact specific material from the reports when

	publication would present a clear and specific threat to the safety and security of a facility but must indicate the nature of the redacted material. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency redacts material from an annual report for publication, the redactions are limited to specific materials where publication would present a clear and specific threat to the safety and security of the facility. In addition, the agency indicates the nature of redacted material. A review of the agency PREA 2022/2023 Annual Report did not have any personal identifiers. All personal identifiers were removed from the Annual report. Interviews PREA Coordinator: The interviewed PREA Coordinator reported that any personal identifying information of staff or clients would be redacted. We have not had an incident at this site. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.389	**Data storage, publication, and destruction**
	Auditor Overall Determination: Meets Standard
	Auditor Discussion
	The following evidence was analyzed in making compliance determination: Documents: 1. Documents:

a. Pre-Audit Questionnaire (PAQ)

b. Policy 11.4 Collection and Storage

c. Policy 13.8.1 Protection from Sexual Abuse and Assault

d. Website: https://static1.squarespace.com/static/598b3628197aea4997aafcfb/t/661d88db102fad5a6f89a545/1713211611368/115.387+PREA+Data+Report+-+Comparison.pdf

2. Interviews:

a. PREA coordinator

Findings (By Provision):

115.389 (a). The agency shall ensure that data collected pursuant to § 115.387 is securely retained.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

The facility reported in the PAQ that incident-based and aggregated data is securely retained. Policy: Prison Rape Elimination Act (PREA), (pg. 19), 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.

Policy 11.4 Collection and Storage provides the agency process for securely collecting and maintaining data (p. 1).

Site Review:

RECORD STORAGE

During the site review, the auditor must:

o The auditor observed the location of the physical storage of the PREA screenings and medical documentation. The documents were placed in a locked file cabinet in the nurse’s station. The information is limited to the medical staff and to the site director.

o The site uses paper instruments to complete PREA screenings and other intake medical related screenings. As previously discussed, the documents are held in a locked file cabinet in the nursing area.

o There currently isn’t a nurse onsite however the director who is also a nurse is filling in for that vacancy. The director provided the auditor with access to see where the files were stored. In addition, full resident files for current and prior residents are

	locked in an office in a locked storage cabinet. o Sexual abuse allegations are stored in a locked file cabinet in the director's office. Final copies are sent the PREA Coordinator at the agency headquarters. Interviews PREA Coordinator: The interviewed PREA Coordinator reported that all data is filed in the office of the PREA Coordinator. Upon review of each PREA related incident, any identified areas of concern are addressed through corrective action. Corrective Actions: N/A. There are no corrective actions for this provision. 115.389 (b). The agency shall 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. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, agency policy requires that aggregated sexual abuse data from facilities under its direct control and private facilities with which it contracts be made readily available to the public, at least annually, through its website. Policy 11.4 Collection and Storage provides the agency process for securely collecting and maintaining data (p. 1). Policy 13.8.1 Protection from Sexual Abuse and Assault states that ". SAYS shall 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" (p. 14). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.389 (c). Before making aggregated sexual abuse data publicly available, the agency shall remove all personal identifiers. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because:

	As reported in the PAQ, before making aggregated sexual abuse data publicly available, the agency removes all personal identifiers. A review of the agency website did not have any personal identifiers. All personal identifiers were removed from the Annual report. Website: https://static1.squarespace.com/static/598b3628197aea4997aafcfb/t/661d88db102fad5a6f89a545/1713211611368/115.387+PREA+Data+Report+-+Comparison.pdf Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.389 (d). The agency shall maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: As reported in the PAQ, the agency maintains sexual abuse data collected pursuant to §115.387 for at least 10 years after the date of initial collection, unless federal, state, or local law requires otherwise. The agency complies with this provision by maintaining at least 10 years of initial data collection. Policy 11.4 Collection and Storage provides the agency process for securely collecting and maintaining data (p. 1). Policy 13.8.1 Protection from Sexual Abuse Assault states that “All case records associated with claims of sexual abuse, including incident reports, investigative reports, juvenile information, case disposition, medical and counseling evaluation findings, and recommendations for post-release treatment and/or counseling shall be retained in accordance with the SAYS record retention schedule. The agency shall maintain sexual abuse data collected pursuant to 115.387 for at least 10 years after the date of its initial collection unless Federal, State, or local law requires otherwise” (p. 14). Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility

	documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.401 Frequency and scope of audits

Auditor Overall Determination: Meets Standard

Auditor Discussion

The following evidence was analyzed in making compliance determination:

Documents:

· Website: https://static1.squarespace.com/static/598b3628197aea4997aafcfb/t/661d88db102fad5a6f89a545/1713211611368/115.387+PREA+Data+Report+-+Comparison.pdf

Findings (By Provision):

115.401 (a). During the three-year period starting on August 20, 2013, and during each three-year period thereafter, the agency shall ensure that each facility operated by the agency, or by a private organization on behalf of the agency, is audited at least once.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

A review of the agency's website provided PREA audit reports according to cycles.

The facility PREA reports are included on the agency website.

DCS Annual Inspection

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.401 (b). As reported by the PREA coordinator, the FACILITY is operated by a private entity (Southeast Alabama Youth Services), a contractor for Alabama Division of Youth Services.

Compliance Determination:

	The facility has demonstrated compliance with this provision of the standard because: A review of the agency's website provided PREA audit reports according to cycles. The facility PREA reports are included on the agency website. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.401 (h). During the inspection of the physical plant the auditor and was escorted throughout the facility by the Director. 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 observe freely, with entry provided to all areas without prohibition. Based on review of documentation the facility is compliant with the intent of the provision. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: On the first day of the audit after the entrance conference, the auditor conducted a comprehensive tour of the facility. It was requested that when the auditor pauses to speak to a resident or staff, that staff on the tour please step away so the conversation might remain private. This request was well respected. During the site review the auditor made numerous observations, including the posting of Notices of PREA Audits, PREA Related Posters, and TIP Posters (with phone numbers to call to report any concern or condition), notices advising resident that female staff routinely work in the facility, locations of showers and privacy issues, bathrooms, medical/grievance boxes, requests forms and boxes for requests, configuration of living units, capacities of dorm/bed rooms, observations of blind spots, camera deployment, the use of mirrors to mitigate blind spots, staffing levels, supervision of resident, accessibility to telephones and instructions for using the phones to report sexual abuse, main control room, dayroom, classrooms, etc.. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. 115.401 (i). During the on-site visit, the auditor was provided access to any and 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.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

The auditor provided the facility with a documentation checklist. The checklist is organized by standards to help the facility through the pre-audit, onsite and post audit phase and to provide the requested documentation by auditor.

The PREA coordinator/compliance manager provided the auditor with all relevant documents as requested.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.401 (m). The auditor provided private rooms throughout the facility to conduct resident interviews. The staff staged the residents in a fashion that the auditor did not have to wait between interviews. The rooms provided for resident interviews were soundproof and somewhat visually confidential from other residents who were 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.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

During the pre-audit period, the facility received instructions to post the required PREA Audit Notice of the upcoming audit prior to the on-site visit for confidential communications. The facility posted the notices in English and Spanish. The auditor received email and pictures confirming the posted notices and observed the posted notices on-site.

As of October 7, 2024, there was no communication from a resident or staff. Staff interviews indicated that Residents are permitted to send confidential information or correspondence in the same manner as if they were communicating with legal counsel.

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

115.401 (n). Residents were able to submit confidential information via written letters to the auditor PO Box or during the interviews with the auditor. The auditor did not receive any correspondence from the residents of the facility.

Compliance Determination:

The facility has demonstrated compliance with this provision of the standard because:

The auditor reached out to the following organizations:

- o National Child Abuse Hotline
- o Ruth House
- o Alabama DYS

Corrective Actions:

N/A. There are no corrective actions for this provision.

Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision.

Overall Findings:

The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

115.403 Audit contents and findings

Auditor Overall Determination: Meets Standard

Auditor Discussion

The following evidence was analyzed in making compliance determination:

Documents:

· Website: https://static1.squarespace.com/static/598b3628197aea4997aafcfb/t/661d88db102fad5a6f89a545/1713211611368/115.387+PREA+Data+Report+-+Comparison.pdf

Findings (By Provision):

	115.403 (f). The agency shall ensure that the auditor's final report is published on the agency's website if it has one or is otherwise made readily available to the public. Compliance Determination: The facility has demonstrated compliance with this provision of the standard because: · The facility's final PREA reports are published on the agency website. Corrective Actions: N/A. There are no corrective actions for this provision. Based on review and analysis of the available evidence, the auditor has determined that the agency and facility are fully compliant with this provision. Overall Findings: The auditor uses a triangulation approach, by connecting the PREA facility documentation, agency policies, on-site observation, site review of the facility, facility practices, interviewed staff and residents, local and national advocates, and online PREA Audit: Pre-Audit Questionnaire to make determinations. Based on analysis, the facility is compliant with all provisions in this standard.

Appendix: Provision Findings		
115.311 (a)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Does the agency have a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment?	yes
	Does the written policy outline the agency’s approach to preventing, detecting, and responding to sexual abuse and sexual harassment?	yes
115.311 (b)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	Has the agency employed or designated an agency-wide PREA Coordinator?	yes
	Is the PREA Coordinator position in the upper-level of the agency hierarchy?	yes
	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
115.311 (c)	**Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**	
	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
	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
115.312 (a)	**Contracting with other entities for the confinement of residents**	
	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.)	na
115.312 (b)	**Contracting with other entities for the confinement of residents**	

	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 OR the response to 115.312(a)-1 is "NO".)	na
115.313 (a)	**Supervision and monitoring**	
	Does the agency ensure that each facility has developed a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility has implemented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility has documented a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The prevalence of substantiated and unsubstantiated incidents of sexual abuse?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Generally accepted juvenile detention and correctional/secure residential practices?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any judicial findings of inadequacy?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any findings of inadequacy from Federal investigative agencies?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate	yes

	staffing levels and determining the need for video monitoring: Any findings of inadequacy from internal or external oversight bodies?	
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: All components of the facility’s physical plant (including “blind-spots” or areas where staff or residents may be isolated)?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The composition of the resident population?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: The number and placement of supervisory staff?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Institution programs occurring on a particular shift?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any applicable State or local laws, regulations, or standards?	yes
	Does the agency ensure that each facility’s staffing plan takes into consideration the 11 criteria below in calculating adequate staffing levels and determining the need for video monitoring: Any other relevant factors?	yes
115.313 (b)	**Supervision and monitoring**	
	Does the agency comply with the staffing plan except during limited and discrete exigent circumstances?	yes
	In circumstances where the staffing plan is not complied with, does the facility fully document all deviations from the plan? (N/A if no deviations from staffing plan.)	na
115.313 (c)	**Supervision and monitoring**	
	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 only until October 1, 2017.)	yes

	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 only until October 1, 2017.)	yes
	Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A only until October 1, 2017.)	yes
	Does the facility ensure only security staff are included when calculating these ratios? (N/A only until October 1, 2017.)	yes
	Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph?	yes
115.313 (d)	**Supervision and monitoring**	
	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
	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
	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
	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
115.313 (e)	**Supervision and monitoring**	
	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
	Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities)	yes
	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	yes

	functions of the facility? (N/A for non-secure facilities)	
115.315 (a)	**Limits to cross-gender viewing and searches**	
	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
115.315 (b)	**Limits to cross-gender viewing and searches**	
	Does the facility always refrain from conducting cross-gender pat-down searches in non-exigent circumstances?	yes
115.315 (c)	**Limits to cross-gender viewing and searches**	
	Does the facility document and justify all cross-gender strip searches and cross-gender visual body cavity searches?	yes
	Does the facility document all cross-gender pat-down searches?	yes
115.315 (d)	**Limits to cross-gender viewing and searches**	
	Does the facility implement 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?	yes
	Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit?	yes
	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
115.315 (e)	**Limits to cross-gender viewing and searches**	
	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
	If a resident’s genital status is unknown, does the facility	yes

	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?	
115.315 (f)	**Limits to cross-gender viewing and searches**	
	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
	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
115.316 (a)	**Residents with disabilities and residents who are limited English proficient**	
	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
	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
	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
	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
	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:	yes

	Residents who have speech disabilities?	
	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
	Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing?	yes
	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
	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
	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
	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: Who are blind or have low vision?	yes
115.316 (b)	**Residents with disabilities and residents who are limited English proficient**	
	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
	Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary?	yes
115.316 (c)	**Residents with disabilities and residents who are limited English proficient**	
	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	yes

	safety, the performance of first-response duties under §115.364, or the investigation of the resident's allegations?	
115.317 (a)	**Hiring and promotion decisions**	
	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
	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
	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 bullet immediately above?	yes
	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
	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
	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 two bullets immediately above?	yes
115.317 (b)	**Hiring and promotion decisions**	
	Does the agency 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?	yes
115.317	**Hiring and promotion decisions**	

(c)		
	Before hiring new employees who may have contact with residents, does the agency: Perform a criminal background records check?	yes
	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
	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
115.317 (d)	**Hiring and promotion decisions**	
	Does the agency perform a criminal background records check before enlisting the services of any contractor who may have contact with residents?	yes
	Does the agency consult applicable child abuse registries before enlisting the services of any contractor who may have contact with residents?	yes
115.317 (e)	**Hiring and promotion decisions**	
	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
115.317 (f)	**Hiring and promotion decisions**	
	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
	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	yes

	employees?	
	Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct?	yes
115.317 (g)	**Hiring and promotion decisions**	
	Does the agency consider material omissions regarding such misconduct, or the provision of materially false information, grounds for termination?	yes
115.317 (h)	**Hiring and promotion decisions**	
	Unless prohibited by law, 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
115.318 (a)	**Upgrades to facilities and technologies**	
	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
115.318 (b)	**Upgrades to facilities and technologies**	
	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.)	na
115.321 (a)	**Evidence protocol and forensic medical examinations**	

	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
115.321 (b)	**Evidence protocol and forensic medical examinations**	
	Is this protocol developmentally appropriate for youth? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.)	yes
	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
115.321 (c)	**Evidence protocol and forensic medical examinations**	
	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
	Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible?	yes
	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
	Has the agency documented its efforts to provide SAFEs or SANEs?	yes
115.321 (d)	**Evidence protocol and forensic medical examinations**	
	Does the agency attempt to make available to the victim a victim advocate from a rape crisis center?	yes

	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?	yes
	Has the agency documented its efforts to secure services from rape crisis centers?	yes
115.321 (e)	**Evidence protocol and forensic medical examinations**	
	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
	As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals?	yes
115.321 (f)	**Evidence protocol and forensic medical examinations**	
	If the agency itself is not responsible for investigating allegations of sexual abuse, has the agency requested that the investigating entity follow the requirements of paragraphs (a) through (e) of this section? (N/A if the agency is responsible for investigating allegations of sexual abuse.)	yes
115.321 (h)	**Evidence protocol and forensic medical examinations**	
	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? (Check N/A if agency attempts to make a victim advocate from a rape crisis center available to victims per 115.321(d) above.)	na
115.322 (a)	**Policies to ensure referrals of allegations for investigations**	
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual abuse?	yes
	Does the agency ensure an administrative or criminal investigation is completed for all allegations of sexual harassment?	yes

115.322 (b)	Policies to ensure referrals of allegations for investigations	
	Does the agency have a policy 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
	Has the agency published such policy on its website or, if it does not have one, made the policy available through other means?	yes
	Does the agency document all such referrals?	yes

115.322 (c)	Policies to ensure referrals of allegations for investigations	
	If a separate entity is responsible for conducting criminal investigations, does such publication 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

115.331 (a)	Employee training	
	Does the agency train all employees who may have contact with residents on: Its zero-tolerance policy for sexual abuse and sexual harassment?	yes
	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
	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
	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
	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
	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

	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
	Does the agency train all employees who may have contact with residents on: How to avoid inappropriate relationships with residents?	yes
	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
	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
	Does the agency train all employees who may have contact with residents on: Relevant laws regarding the applicable age of consent?	yes
115.331 (b)	**Employee training**	
	Is such training tailored to the unique needs and attributes of residents of juvenile facilities?	yes
	Is such training tailored to the gender of the residents at the employee's facility?	yes
	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
115.331 (c)	**Employee training**	
	Have all current employees who may have contact with residents received such training?	yes
	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
	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

115.331 (d)	**Employee training**	
	Does the agency document, through employee signature or electronic verification, that employees understand the training they have received?	yes
115.332 (a)	**Volunteer and contractor training**	
	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
115.332 (b)	**Volunteer and contractor training**	
	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
115.332 (c)	**Volunteer and contractor training**	
	Does the agency maintain documentation confirming that volunteers and contractors understand the training they have received?	yes
115.333 (a)	**Resident education**	
	During intake, do residents receive information explaining the agency's zero-tolerance policy regarding sexual abuse and sexual harassment?	yes
	During intake, do residents receive information explaining how to report incidents or suspicions of sexual abuse or sexual harassment?	yes
	Is this information presented in an age-appropriate fashion?	yes
115.333 (b)	**Resident education**	
	Within 10 days of intake, does the agency provide age-appropriate	yes

	comprehensive education to residents either in person or through video regarding: Their rights to be free from sexual abuse and sexual harassment?	
	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
	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
115.333 (c)	**Resident education**	
	Have all residents received such education?	yes
	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
115.333 (d)	**Resident education**	
	Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are deaf?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled?	yes
	Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills?	yes
115.333 (e)	**Resident education**	
	Does the agency maintain documentation of resident participation in these education sessions?	yes
115.333 (f)	**Resident education**	

	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
115.334 (a)	**Specialized training: Investigations**	
	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
115.334 (b)	**Specialized training: Investigations**	
	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
	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
	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
	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
115.334 (c)	**Specialized training: Investigations**	
	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

115.335 (a)	Specialized training: Medical and mental health care	
	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
	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
	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
	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

115.335 (b)	Specialized training: Medical and mental health care	
	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

115.335 (c)	Specialized training: Medical and mental health care	
	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

115.335 (d)	Specialized training: Medical and mental health care	
	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
	Do medical and mental health care practitioners contracted by and 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
115.341 (a)	**Obtaining information from residents**	
	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?	no
	Does the agency also obtain this information periodically throughout a resident's confinement?	yes
115.341 (b)	**Obtaining information from residents**	
	Are all PREA screening assessments conducted using an objective screening instrument?	yes
115.341 (c)	**Obtaining information from residents**	
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Prior sexual victimization or abusiveness?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: 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
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Current charges and offense history?	yes
	During these PREA screening assessments, at a minimum, does	yes

	the agency attempt to ascertain information about: Age?	
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Level of emotional and cognitive development?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical size and stature?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Mental illness or mental disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Intellectual or developmental disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Physical disabilities?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: The resident's own perception of vulnerability?	yes
	During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: Any other specific information about individual residents that may indicate heightened needs for supervision, additional safety precautions, or separation from certain other residents?	yes
115.341 (d)	**Obtaining information from residents**	
	Is this information ascertained: Through conversations with the resident during the intake process and medical mental health screenings?	yes
	Is this information ascertained: During classification assessments?	yes
	Is this information ascertained: By reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files?	yes
115.341 (e)	**Obtaining information from residents**	
	Has the agency implemented appropriate controls on the dissemination within the facility of responses to questions asked	yes

	pursuant to this standard in order to ensure that sensitive information is not exploited to the resident's detriment by staff or other residents?	
115.342 (a)	**Placement of residents**	
	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
	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
	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
	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
	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
115.342 (b)	**Placement of residents**	
	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?	yes
	During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise?	yes
	During any period of isolation, does the agency always refrain from denying residents any legally required educational programming or special education services?	yes
	Do residents in isolation receive daily visits from a medical or mental health care clinician?	yes
	Do residents also have access to other programs and work opportunities to the extent possible?	yes

115.342 (c)	Placement of residents	
	Does the agency always refrain from placing: Lesbian, gay, and bisexual residents in particular housing, bed, or other assignments solely on the basis of such identification or status?	yes
	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
	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
	Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex identification or status as an indicator or likelihood of being sexually abusive?	yes

115.342 (d)	Placement of residents	
	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
	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

115.342 (e)	Placement of residents	
	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

115.342 (f)	Placement of residents	
	Are each transgender or intersex resident's own views with respect to his or her own safety given serious consideration when	yes

	making facility and housing placement decisions and programming assignments?	
115.342 (g)	**Placement of residents**	
	Are transgender and intersex residents given the opportunity to shower separately from other residents?	yes
115.342 (h)	**Placement of residents**	
	If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The basis for the facility's concern for the resident's safety? (N/A for h and i if facility doesn't use isolation?)	yes
	If a resident is isolated pursuant to paragraph (b) of this section, does the facility clearly document: The reason why no alternative means of separation can be arranged? (N/A for h and i if facility doesn't use isolation?)	yes
115.342 (i)	**Placement of residents**	
	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?	yes
115.351 (a)	**Resident reporting**	
	Does the agency provide multiple internal ways for residents to privately report: Sexual abuse and sexual harassment?	yes
	Does the agency provide multiple internal ways for residents to privately report: 2. Retaliation by other residents or staff for reporting sexual abuse and sexual harassment?	yes
	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
115.351 (b)	**Resident reporting**	
	Does the agency also provide at least one way for residents to report sexual abuse or sexual harassment to a public or private	yes

	entity or office that is not part of the agency?	
	Is that private entity or office able to receive and immediately forward resident reports of sexual abuse and sexual harassment to agency officials?	yes
	Does that private entity or office allow the resident to remain anonymous upon request?	yes
	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?	yes
115.351 (c)	**Resident reporting**	
	Do staff members accept reports of sexual abuse and sexual harassment made verbally, in writing, anonymously, and from third parties?	yes
	Do staff members promptly document any verbal reports of sexual abuse and sexual harassment?	yes
115.351 (d)	**Resident reporting**	
	Does the facility provide residents with access to tools necessary to make a written report?	yes
115.351 (e)	**Resident reporting**	
	Does the agency provide a method for staff to privately report sexual abuse and sexual harassment of residents?	yes
115.352 (a)	**Exhaustion of administrative remedies**	
	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
115.352 (b)	**Exhaustion of administrative remedies**	

	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
	Does the agency always refrain from requiring an 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
115.352 (c)	**Exhaustion of administrative remedies**	
	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
	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
115.352 (d)	**Exhaustion of administrative remedies**	
	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
	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
	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
115.352 (e)	**Exhaustion of administrative remedies**	

	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
	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
	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
	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
	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
115.352 (f)	**Exhaustion of administrative remedies**	
	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
	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
	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

	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
	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
	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
	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
115.352 (g)	**Exhaustion of administrative remedies**	
	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
115.353 (a)	**Resident access to outside confidential support services and legal representation**	
	Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making accessible mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations?	yes
	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?	yes
	Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible?	yes
115.353 (b)	**Resident access to outside confidential support services and legal representation**	
	Does the facility inform residents, prior to giving them access, of the extent to which such communications will be monitored and	yes

	the extent to which reports of abuse will be forwarded to authorities in accordance with mandatory reporting laws?	
115.353 (c)	**Resident access to outside confidential support services and legal representation**	
	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
	Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements?	yes
115.353 (d)	**Resident access to outside confidential support services and legal representation**	
	Does the facility provide residents with reasonable and confidential access to their attorneys or other legal representation?	yes
	Does the facility provide residents with reasonable access to parents or legal guardians?	yes
115.354 (a)	**Third-party reporting**	
	Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment?	yes
	Has the agency distributed publicly information on how to report sexual abuse and sexual harassment on behalf of a resident?	yes
115.361 (a)	**Staff and agency reporting duties**	
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment?	yes
	Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or	yes

	information they receive regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation?	
115.361 (b)	**Staff and agency reporting duties**	
	Does the agency require all staff to comply with any applicable mandatory child abuse reporting laws?	yes
115.361 (c)	**Staff and agency reporting duties**	
	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
115.361 (d)	**Staff and agency reporting duties**	
	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
	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
115.361 (e)	**Staff and agency reporting duties**	
	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
	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
	If the 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	yes

	the parents or legal guardians? (N/A if the alleged victim is not under the guardianship of the child welfare system.)	
	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
115.361 (f)	**Staff and agency reporting duties**	
	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
115.362 (a)	**Agency protection duties**	
	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
115.363 (a)	**Reporting to other confinement facilities**	
	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
	Does the head of the facility that received the allegation also notify the appropriate investigative agency?	yes
115.363 (b)	**Reporting to other confinement facilities**	
	Is such notification provided as soon as possible, but no later than 72 hours after receiving the allegation?	yes
115.363 (c)	**Reporting to other confinement facilities**	
	Does the agency document that it has provided such notification?	yes
115.363 (d)	**Reporting to other confinement facilities**	
	Does the facility head or agency office that receives such notification ensure that the allegation is investigated in	yes

	accordance with these standards?	
115.364 (a)	**Staff first responder duties**	
	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
	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
	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
	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
115.364 (b)	**Staff first responder duties**	
	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
115.365 (a)	**Coordinated response**	
	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
115.366 (a)	**Preservation of ability to protect residents from contact with abusers**	

	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
115.367 (a)	**Agency protection against retaliation**	
	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
	Has the agency designated which staff members or departments are charged with monitoring retaliation?	yes
115.367 (b)	**Agency protection against retaliation**	
	Does the agency employ multiple protection measures for residents or staff who fear retaliation for reporting sexual abuse or sexual harassment or for cooperating with investigations, 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?	yes
115.367 (c)	**Agency protection against retaliation**	
	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
	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
	Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report	yes

	of sexual abuse, does the agency: Act promptly to remedy any such retaliation?	
	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
	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
	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
	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
	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
	Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need?	yes
115.367 (d)	**Agency protection against retaliation**	
	In the case of residents, does such monitoring also include periodic status checks?	yes
115.367 (e)	**Agency protection against retaliation**	
	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
115.368 (a)	**Post-allegation protective custody**	
	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

115.371 (a)	Criminal and administrative agency investigations	
	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 does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	yes
	Does the agency conduct such investigations for all allegations, including third party and anonymous reports? (N/A if the agency does not conduct any form of administrative or criminal investigations of sexual abuse or harassment. See 115.321(a).)	yes
115.371 (b)	**Criminal and administrative agency investigations**	
	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
115.371 (c)	**Criminal and administrative agency investigations**	
	Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data?	yes
	Do investigators interview alleged victims, suspected perpetrators, and witnesses?	yes
	Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator?	yes
115.371 (d)	**Criminal and administrative agency investigations**	
	Does the agency always refrain from terminating an investigation solely because the source of the allegation recants the allegation?	yes
115.371 (e)	**Criminal and administrative agency investigations**	
	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
115.371	**Criminal and administrative agency investigations**	

(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
	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
115.371 (g)	**Criminal and administrative agency investigations**	
	Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse?	yes
	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
115.371 (h)	**Criminal and administrative agency investigations**	
	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
115.371 (i)	**Criminal and administrative agency investigations**	
	Are all substantiated allegations of conduct that appears to be criminal referred for prosecution?	yes
115.371 (j)	**Criminal and administrative agency investigations**	
	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
115.371 (k)	**Criminal and administrative agency investigations**	
	Does the agency ensure that the departure of an alleged abuser or victim from the employment or control of the facility or agency	yes

	does not provide a basis for terminating an investigation?	
115.371 (m)	**Criminal and administrative agency investigations**	
	When an outside entity 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
115.372 (a)	**Evidentiary standard for administrative investigations**	
	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
115.373 (a)	**Reporting to residents**	
	Following an investigation into a resident's allegation of sexual abuse suffered in the facility, does the agency inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded?	yes
115.373 (b)	**Reporting to residents**	
	If the agency did not conduct the investigation into a resident's allegation of sexual abuse in an agency 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
115.373 (c)	**Reporting to residents**	
	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
	Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency	yes

	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?	
	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
	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
115.373 (d)	**Reporting to residents**	
	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
	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
115.373 (e)	**Reporting to residents**	
	Does the agency document all such notifications or attempted notifications?	yes
115.376 (a)	**Disciplinary sanctions for staff**	
	Are staff subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies?	yes

115.376 (b)	**Disciplinary sanctions for staff**	
	Is termination the presumptive disciplinary sanction for staff who have engaged in sexual abuse?	yes
115.376 (c)	**Disciplinary sanctions for staff**	
	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
115.376 (d)	**Disciplinary sanctions for staff**	
	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
	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
115.377 (a)	**Corrective action for contractors and volunteers**	
	Is any contractor or volunteer who engages in sexual abuse prohibited from contact with residents?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Law enforcement agencies (unless the activity was clearly not criminal)?	yes
	Is any contractor or volunteer who engages in sexual abuse reported to: Relevant licensing bodies?	yes
115.377 (b)	**Corrective action for contractors and volunteers**	
	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

115.378 (a)	Interventions and disciplinary sanctions for residents	
	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

115.378 (b)	Interventions and disciplinary sanctions for residents	
	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
	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
	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
	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
	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

115.378 (c)	Interventions and disciplinary sanctions for residents	
	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

115.378 (d)	Interventions and disciplinary sanctions for residents	
	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

	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
115.378 (e)	**Interventions and disciplinary sanctions for residents**	
	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
115.378 (f)	**Interventions and disciplinary sanctions for residents**	
	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
115.378 (g)	**Interventions and disciplinary sanctions for 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
115.381 (a)	**Medical and mental health screenings; history of sexual abuse**	
	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
115.381 (b)	**Medical and mental health screenings; history of sexual abuse**	
	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
115.381 (c)	**Medical and mental health screenings; history of sexual abuse**	

	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
115.381 (d)	**Medical and mental health screenings; history of sexual abuse**	
	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
115.382 (a)	**Access to emergency medical and mental health services**	
	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
115.382 (b)	**Access to emergency medical and mental health services**	
	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
	Do staff first responders immediately notify the appropriate medical and mental health practitioners?	yes
115.382 (c)	**Access to emergency medical and mental health services**	
	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
115.382 (d)	**Access to emergency medical and mental health services**	
	Are treatment services provided to the victim without financial	yes

	cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident?	
115.383 (a)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	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
115.383 (b)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	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
115.383 (c)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Does the facility provide such victims with medical and mental health services consistent with the community level of care?	yes
115.383 (d)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if all-male facility.)	na
115.383 (e)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	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.)	na
115.383 (f)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate?	yes
115.383 (g)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or	yes

	cooperates with any investigation arising out of the incident?	
115.383 (h)	**Ongoing medical and mental health care for sexual abuse victims and abusers**	
	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
115.386 (a)	**Sexual abuse incident reviews**	
	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
115.386 (b)	**Sexual abuse incident reviews**	
	Does such review ordinarily occur within 30 days of the conclusion of the investigation?	yes
115.386 (c)	**Sexual abuse incident reviews**	
	Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners?	yes
115.386 (d)	**Sexual abuse incident reviews**	
	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
	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
	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
	Does the review team: Assess the adequacy of staffing levels in that area during different shifts?	yes

	Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff?	yes
	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
115.386 (e)	**Sexual abuse incident reviews**	
	Does the facility implement the recommendations for improvement, or document its reasons for not doing so?	yes
115.387 (a)	**Data collection**	
	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
115.387 (b)	**Data collection**	
	Does the agency aggregate the incident-based sexual abuse data at least annually?	yes
115.387 (c)	**Data collection**	
	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
115.387 (d)	**Data collection**	
	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
115.387 (e)	**Data collection**	
	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	na

	the confinement of its residents.)	
115.387 (f)	**Data collection**	
	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.)	na
115.388 (a)	**Data review for corrective action**	
	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
	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
	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
115.388 (b)	**Data review for corrective action**	
	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
115.388 (c)	**Data review for corrective action**	
	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
115.388 (d)	**Data review for corrective action**	
	Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when	yes

	publication would present a clear and specific threat to the safety and security of a facility?	
115.389 (a)	**Data storage, publication, and destruction**	
	Does the agency ensure that data collected pursuant to § 115.387 are securely retained?	yes
115.389 (b)	**Data storage, publication, and destruction**	
	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
115.389 (c)	**Data storage, publication, and destruction**	
	Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available?	yes
115.389 (d)	**Data storage, publication, and destruction**	
	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
115.401 (a)	**Frequency and scope of audits**	
	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
115.401 (b)	**Frequency and scope of audits**	
	Is this the first year of the current audit cycle? (Note: a “no” response does not impact overall compliance with this standard.)	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.)	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
115.401 (h)	**Frequency and scope of audits**	
	Did the auditor have access to, and the ability to observe, all areas of the audited facility?	yes
115.401 (i)	**Frequency and scope of audits**	
	Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)?	yes
115.401 (m)	**Frequency and scope of audits**	
	Was the auditor permitted to conduct private interviews with inmates, residents, and detainees?	yes
115.401 (n)	**Frequency and scope of audits**	
	Were inmates, residents, and detainees permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel?	yes
115.403 (f)	**Audit contents and findings**	
	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 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, there has never been a Final Audit Report issued.)	yes