PREA AUDIT REPORT ☐ INTERIM ☒ FINAL

JUVENILE FACILITIES

Date of report: July 30, 2015

Auditor Information			
Auditor name: Dan McGehee			
Address: PO Box 595, White Rock, SC 29177			
Email: mc72fsud@aol.com			
Telephone number: 803-331-0264			
Date of facility visit: June 30, 2015 – July 1, 2015			
Facility Information			
Facility name: State of Alabama Department of Youth Services, Vacca Campus			
Facility physical address: 8950 Roebuck Blvd. Birmingham, Alabama 35206			
Facility mailing address: *(if different from above)* Click here to enter text.			
Facility telephone number: 205-838-4900			
The facility is:	☐ Federal	☒ State	☐ County
	☐ Military	☐ Municipal	☐ Private for profit
	☐ Private not for profit		
Facility type:	☒ Correctional	☐ Detention	☐ Other
Name of facility's Chief Executive Officer: Yolanda Byrdsong			
Number of staff assigned to the facility in the last 12 months: 110			
Designed facility capacity: 70			
Current population of facility: 52			
Facility security levels/inmate custody levels: secure residential facility/high			
Age range of the population: 13-18			
Name of PREA Compliance Manager: Alicia M. Faire		**Title:** Vacca Campus PREA Compliance Manager	
Email address: Alicia.faire@dys.alabama.gov		**Telephone number:** 205-838-4906	
Agency Information			
Name of agency: Alabama Department of Youth Services			
Governing authority or parent agency: *(if applicable)* State of Alabama			
Physical address: 1000 Industrial School Rd Mt. Meigs, Alabama 36057			
Mailing address: *(if different from above)* PO Box 66 Mt. Meigs, Alabama 36057			
Telephone number: 334-215-3800			
Agency Chief Executive Officer			
Name: Steven P. Lafreniere		**Title:** Executive Director	
Email address: steven.lafreniere@dys.alabama.gov		**Telephone number:** 334-215-3800	
Agency-Wide PREA Coordinator			
Name: Bobby Latham		**Title:** DYS PREA and ACA Coordinator	
Email address: 8950 Roebuck Blvd Birmingham, Alabama 35206		**Telephone number:** 205-836-6618	

AUDITFINDINGS

NARRATIVE

The PREA audit of the Vacca Campus of the Alabama Department of Youth Services was conducted by Dan McGehee, chair, and Richard Bazzle, auditor, representing McB Consultant Services on June 30 and July 1, 2015. The auditors met with senior staff for dinner on the evening of June 29. The formal entrance briefing was conducted with five senior staff members at 8:00 am on June 30, 2015. The chair explained the purpose of the audit as well as reviewed a time frame for audit activities. Questions were welcomed and answered. Following the entrance briefing, auditors toured the facility separately with local staff and visited student housing areas, the cafeteria, school, gymnasium, chapel, medical and administration.
From the tour the auditors had the following concerns:
Blinds were located on all dorm offices and windows were completely covered. There were no sight lines in or out. Upon discussing this with the facililty director and her staff, the blinds and hardware were removed by the end of the day.

In the two older dorms, student's single rooms were not locked when students exited. Students congregated in dayrooms under supervision of staff or in their individual rooms unsupervised. Auditors recommended that upon exiting their rooms, these high security students should be directly supervised by staff at all times in dayrooms. The policy was changed July 8, 2015 to reflect that all residents exit their rooms at the same time, at which time the doors to their rooms are locked, thus allowing for constant supervision by staff.

Again in the older dorms, bathrooms containing multiple urinals, toilets, and showers afforded no privacy for student use. In discussions with staff, the auditors recommended several possible solutions to remedy this. The agency decided to add saloon type doors at the entrance to the bathrooms of the two older dorms. Picture documentation was sent to the audit chair verifying completion on July 13, 2015.

Solid doors were evident throughout the facility. To support training efforts, auditors recommended placing "Employee Only" signs on these doors as students are not allowed in these areas. This was completed by the end of the first day campus-wide. Red lines were supposedly used in dorms and the cafeteria as a means of keeping students out of restricted areas. However, the red lines were worn off in many areas and were not readily visible. Picture documentation was sent to the chair on July 13, 2015, documenting newly striped red lines throughout the facility.

The residents bathrooms in the newer dorms are located under the stairs leading to the top tier. The stairway blocks all visibility of the bathroom doors. There is no camera observation or staff observation of this area. The agency has placed locks on the doors, and the bathrooms will only be accessible by staff unlocking the doors. These bathrooms are used infrequently, due to the fact that students have a toilet and sink in their individual rooms.

The entrance to the unused shower/dressing room area of the gym is open and not secure; however, it is next to the restroom area and is accessbile to students walking down the hallway. The recommendation is that the entrance to this area be enclosed with a door to secure the area. Picture documentation was received by the audit chair on July 13, 2015, showing enclosure of this area with a door that can be locked.

The balance of the first day was spent by auditors reviewing additional documentation, scanning documents, and interviewing both staff and students. Staff members interviewed included the agency head designee, PREA coordinator, PREA compliance manager, and eleven specialized and random staff; eight residents, representing each housing unit were also interviewed. Staff were from all shifts and their interviews indicated that both staff and residents have received the required PREA training.
A daily closeout was conducted at 4:30 pm by the audit team with senior staff. The chair summarized the day's activities and staff explained what had been done to mitigate auditor concerns. The auditors exited the facility at 5:00 pm.

On July 1, the auditors entered the facility at 6:45 am in order to speak with staff from the evening shift. Staff from all three shifts were interviewed, as well as campus operations observed.
At 7:30 am the chair spoke with the statewide maintenance director for DYS who said that private contractors would begin work July 6 on student bathrooms in the two older dorms, as well as an area in the gym which auditors thought should be closed off, since it was not currently being utilized, and afforded unsupervised access to students.

The balance of the morning of July 1 was spent conducting staff interviews and reviewing further documentation.

The formal closeout for the audit was conducted by the auditors at 11:00 am with senior staff. The audit chair commended the staff for the hard work in implementing policy, procedure, and practice for PREA standard compliance. He thanked staff for the spirit in which auditor suggestions had been received and the immediacy in implementing recommended changes. The chair reviewed the time frame for completing the audit report and for determining compliance with all applicable PREA standards. The auditors exited the facility at 12 noon.

DESCRIPTION OF FACILITY CHARACTERISTICS

The Vacca Campus, previously known as "the Alabama Boys Industrial School", was founded in 1899 by Mrs. R. D. Johnston. After witnessing young delinquent boys working in prison mining camps, Mrs. Johnston set out to build an institution that was not only a reformatory school, but a place where boys might be guided into a better way of life. The campus is located on 178 scenic acres in Birmingham in the Roebuck community.

The Department of Youth Services assumed control of the facility in 1975 at which time the institution provided special emphasis on education remediation for students. In 1991 the campus was designated as one of two facilities in the State for placement of serious juvenile offenders.

Currently, the Vacca Campus is a multifaceted, secure juvenile correctional institution serving male youth ages thirteen to eighteen. The youth are adjudicated juvenile offenders who are court-committed to DYS. Services include an educational program, substance abuse education and treatment, medical and mental health services, individual and group counseling, physical education, and other basic services important to positive youth development. Each youth is assigned a case manager and works with that counselor toward addressing factors related to committing offenses, developing life skills, and earning release by completing an Individualized Service Plan (ISP) developed by a multidisciplinary team.

Substance abuse and chemical dependency treatment is provided by the educational component of the University of Alabama at Birmingham (UAB) Substance Abuse Program or the more intensive Chemical Addiction Program (CAP). Additional group counseling includes topics ranging from social skills to release and aftercare preparations.

The programs and services offered by Vacca Campus are designed to provide the opportunity for juveniles to return to their communities and function as lawful and productive citizens. Continuing in the footsteps of the facility's founder, the goal remains to guide the students into a better way of life.

SUMMARY OF AUDIT FINDINGS

Agency wide policies and procedures were reviewed and found in compliance with relevant PREA standards. Five standards received a rating of EXCEEDS and thirty-six received a rating of MEETS. With all standards found in compliance, there was no action plan required.

Number of standards exceeded: 5

Number of standards met: 36

Number of standards not met: 0

Number of standards not applicable: 0

Standard 115.311 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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.

(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.

(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

Full compliance with the standard was determined by the following:

Auditors reviewed Policy 13.8.1 Protection from Sexual Abuse/Assault (PREA Policy)

Auditors also reviewed the PREA coordinator desgination and qualifications, interviews with PREA Coordinator and PREA compliance manager

Agency organizational chart

Facility organizational chart

Standard 115.312 Contracting with other entities for the confinement of residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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

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

Full compliance with the standard was determined by the following:

Auditors reviewed Policy 13.8.1 Protection from Sexual abuse/assault (PREA)
Contract with Department of Youth Services
PREA form 115.312 Contract Private Provider Receipt of PREA procedures regarding prevention, detection, and reporting.

Standard 115.313 Supervision and monitoring

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(a) The agency shall ensure that each facility it operates shall develop, implement, and document a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. In calculating adequate staffing levels and determining the need for video monitoring, facilities shall take into consideration:
(1) Generally accepted juvenile detention and correctional/secure residential practices;
(2) Any judicial findings of inadequacy;
(3) Any findings of inadequacy from Federal investigative agencies;
(4) Any findings of inadequacy from internal or external oversight bodies;
(5) All components of the facility's physical plant (including "blind spots" or areas where staff or residents may be isolated);
(6) The composition of the resident population;
(7) The number and placement of supervisory staff;
(8) Institution programs occurring on a particular shift;
(9) Any applicable State or local laws, regulations, or standards;
(10) The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and
(11) Any other relevant factors.
(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

(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 shall 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.

(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
(4) The resources the facility has available to commit to ensure adherence to the staffing plan.

(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.

Full compliance with the standard was determined by the following:
Auditors reviewed sample staffing reports for 4 months of 2014 and 3 months of 2015
Facililty vulnerability assessments for 2013, 2014, and 2015
Facility daily activity schedule, supervisory monitoring log, and work schedule
Group counseling schedule, security count affidavit, daily population report
Annual survey of sexual victimization for 2013
Annual review of staffing assessment
Employee interviews

Standard 115.315 Limits to cross-gender viewing and searches

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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.

(b) The agency shall not conduct cross-gender pat-down searches except in exigent circumstances

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

(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

(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

(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 need

Full compliance with the standard was determined by the following:

Auditors reviewed PREA form 115.315 Cross-gender strip searches/visual body cavity searches/cross gender pat-down searches documenting that no occurances had occurred; auditors also reviewed shift duty assignments, medical reports, training records (on cross-gender searches), Log book entries (opposite gender announcements from Sept 2014 to May 2015); interviews with staff and residents

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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.

(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.

(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

Full compliance with the standard was determined by the following:
Auditors reviewed sample copies of Juvenile confirmation of Receipt of PREA training
Contract with Deep South Language Services for providing interpreter/translator services
PREA pamphlets in English and Spanish

Standard 115.317 Hiring and promotion decisions

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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

(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

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

(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.

(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.

(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.

(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

(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.

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

(h) 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.

Full compliance with the standard was determined by the following:
Auditors received a statement from the HR staff person, that all employees and contractors have passed criminal records background checks prior to employment. Further, all long term employees and contractors have passed 5 year criminal records background checks as required by PREA.
Employee interviews

Standard 115.318 Upgrades to facilities and technologies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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.

(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.

Full compliance with the standard was determined by the following:
Auditors reviewed the video surveillance schematics of the facility indicating the location of 119 cameras both interior and exterior.

Standard 115.321 Evidence protocol and forensic medical examinations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(a) To the extent the agency is responsible for investigating allegations of sexual abuse, the agency shall follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions.

(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.

(c) The agency shall 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. 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.

(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.

(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

(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

(g) The requirements of paragraphs (a) through (f) of this section shall also apply to:

(1) Any State entity outside of the agency that is responsible for investigating allegations of sexual abuse in juvenile facilities; and

(2) Any Department of Justice component that is responsible for investigating allegations of sexual abuse in juvenile

facilities.

(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.

Full compliance with the standard was determined by the following:

Auditors reviewed Victim advocate receipt of PREA information, Certificates of training from the Alabama Coalition against Sexual violence for 4 staff members; Certificate of completion of training (End Violence against Women International) on Interviewing the Victim for one staff member; MOA with Birmingham Police Department to provide investigative services to residents and staff of Vacca Campus of the Alabama DYS. Staff interviews

Standard 115.322 Policies to ensure referrals of allegations for investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(a) The agency shall ensure that an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment

(b) The agency shall have in place a policy 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. 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.

(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.

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

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

Full compliance with the standard was determined by the following:

Auditors reviewed documentation of an occurrence of administrative investigation in May 2014, which was determined to be unfounded; reviewed Juvenile notification of investigative outcome from incident

Reviewed website information on PREA;

Documentation that there were no referrals of allegations for investigations to law enforcement occurring between May 1, 2014 and April 30, 2015.

Standard 115.331 Employee training

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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;
- **(10)** How to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities; and
- **(11)** Relevant laws regarding the applicable age of consent.

(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**.**

(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.

(d) The agency shall document, through employee signature or electronic verification that employees understand the training they have received.

Full compliance with the standard was determined by the following:

Auditors reviewed staff receipt of documentation of PREA training; PREA training sign-in sheet for staff; PREA pamphlet titled "What staff should know about sexual misconduct with juveniles"; Statement from Yolanda Byrdsong, Campus Administrator that all employees have received the required PREA training. Employee interviews

Standard 115.332 Volunteer and contractor training

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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

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

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

Full compliance with the standard was determined by the following:

Auditors reviewed Volunteer and contractor receipt of PREA training documents

Statement from Yolanda Byrdsong, Campus Administrator, that all contractors and volunteers have received the required PREA training.

Standard 115.333 Resident education

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states**:**

(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.

(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.

(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.

(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.

(e) The agency shall maintain documentation of resident participation in these education sessions.

(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**.**

Full compliance with the standard was determined by the following:

Auditors reviewed Juvenile confirmation of receipt of PREA information; PREA pamphlet "What you should know about sexual abuse and assault; pamphlet "Your safety at DYS"; PREA orientation Power Point presentation; "sexual assault in the juvenile corrections setting" power point; interpreter contract for language services; PREA posters; Statement from Yolanda Byrdsong, campus administrator, that all residents have received required PREA training. After receiving a grant, the Alabama DYS graphic artist developed colorful PREA posters for the facility, and pamphlets were developed including required PREA information for students.

Standard 115.334 Specialized training: Investigations

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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.
(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.
(c) The agency shall maintain documentation that agency investigators have completed the required specialized training in conducting sexual abuse investigations.
(d) Any State entity or Department of Justice component that investigates sexual abuse in juvenile confinement settings shall provide such training to its agents and investigators who conduct such investigations.

Full compliance with the standard was determined by the following:
Auditors reviewed Investigator receipt of PREA training for 2 employees; (one certificate is for advocacy training, the other has special investigator training); MOA with Birmingham Police Dept to provide investigative services to residents and staff of Vacca campus; Statement from Yolanda Byrdsong, Campus administrator, that two investigators have received the specialized training required to conduct investigations in confinement settings. One newly hired investigator will not conduct PREA related investigations prior to receiving the specialized training required to conduct investigations in confinement settings.

Standard 115.335 Specialized training: Medical and mental health care

☒ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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.

(b) If medical staff employed by the agency conduct forensic examinations, such medical staff shall receive the appropriate training to conduct such examinations.
(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.
(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.

Full compliance with the standard was determined by the following:
Auditors reviewed nurses' certification licences; medical and mental health staff receipt of PREA training; contract medical and mental health receipt of PREA training; Agreement between Alabama DYS and Children's Hospital of Alabama to provide victim assistance and counseling services to the Vacca campus in order to comply with PREA. All medical and mental health staff completed NIC specialized training for this standard. Staff interviews

Standard 115.341 Screening for risk of victimization and abusiveness

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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.

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

(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.

(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.

(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.

Full compliance with the standard was determined by the following:
Auditors reviewed samples of intake screening forms; samples of intake health screening forms; risk assessment form;

form indicating no occurrence of PREA risk assessment; guidelines for confidentiality regarding risk/health information; interviews with staff and residents.

Standard 115.342 Use of screening information

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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

(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.

(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.

(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

(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.

(f) A transgender or intersex resident's own views with respect to his or her own safety shall be given serious consideration

(g) Transgender and intersex residents shall be given the opportunity to shower separately from other residents.

(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.

(i) Every 30 days, the facility shall afford 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.

Full compliance with the standard was determined by the following:

Auditors reviewed guidelines for housing unit placement for residents (there were no occurrences of transgender or intersex residents needing placement); housing unit interview sheet; blank isolation activity log; documentation that no isolation incidents had occurred from May 1, 2014 to April 30, 2015. Intake staff interviews.

Standard 115.351 Resident reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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.

(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 information on how to contact relevant consular officials and relevant officials at the Department of Homeland Security.

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

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

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

Full compliance with the standard was determined by the following:

Auditors reviewed DYS youth grievance form; documentation that there had been no occurrence of juveniles reporting abuse/harassment to a public or private entity; samples of juveniles receipt of PREA information; Alabama PREA hotline message; poster indicating 5 ways to report sexual abuse/harassment; staff and juvenile interviews; Statement from Yolanda Byrdsong, Campus Administrator, that all residents have been trained in the use of the phone for reporting sexual abuse/sexual harassment.

Standard 115.352 Exhaustion of administrative remedies

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

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

(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 otherwise 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.

(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.

(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, of 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.

(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.

(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 in substantial risk of imminent sexual abuse and the action taken in response to the emergency grievance.

(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.

Full compliance with the standard was determined by the following:
Auditors reviewed grievance form(blank); grievance response form; receipt of PREA training by residents; third party report form (blank); documentation of no occurrence of third party reporting from May 1, 2014 to April 30, 2015; letter to parents including PREA information on how to report sexual abuse/sexual harassment.

Standard 115.353 Resident access to outside confidential support services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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 telephones, 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.

(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**.**

(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.

(d) The facility shall also provide residents with reasonable and confidential access to their attorneys or other legal representation and reasonable access to parents or legal guardians.

Full compliance with the standard was determined by the following:

Auditors reviewed MOA with Children's Hospital of Alabama to provide victim assistance and counseling services that comply with PREA; samples of PREA posters; Alabama PREA hotline message; samples of informed student verification indicating receipt of handbook, rights and privileges, etc; juvenile confirmation of receipt of PREA training; important numbers for juveniles to report sexual abuse; memo on student phone access to Alabama Disabilities Advocacy Program (ADAP) representative.

Standard 115.354 Third-party reporting

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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.

Full compliance with the standard was determined by the following:

Auditors reviewed website information; third party reporting form; documentation that there had been no occurrence of third party reporting from May1, 2014 to April 30, 2015

Standard 115.361 Staff and agency reporting duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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.

(b) The agency shall also require all staff to comply with any applicable mandatory child abuse reporting laws.

(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.

(d) (1) 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

(e) (1) 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.
(2) If the alleged victim is under the guardianship of the child welfare system, the report shall be made to the alleged victim's caseworker instead of the parents or legal guardians.
(3) 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.

(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.

Full compliance with the standard was determined by the following:
Auditors reviewed documentation that no occurrence of sexual abuse/harassment had taken place from May 1, 2014 to April 30, 2015; documentation of staff training in PREA; documentation of parent/attorney/guardian notification that no incidents had occurred from May 1, 2014 to April 30, 2015; clinical services release of information form; documentation that no occurrence of treatment for sexual abuse/harassment had occurred from May 1, 2014 to April 30, 2015; confidentiality statement regarding PREA shared information; mandatory Child abuse reporting nonoccurrence from May 1, 2014 to April 30, 2015; child abuse form (blank) for reporting; documentation of anonymous report nonoccurrence from May 1, 2014 to April 30, 2015; third party report form (blank); documentation of third party reporting nonoccurrence from May 1, 2014 to April 30, 2015; documentation of "need to obtain medical consent" nonoccurrence from May 1, 2014 to April 30, 2015.

Standard 115.362 Agency protection duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(a) When an agency learns that a resident is subject to a substantial risk of imminent sexual abuse, it shall take immediate action to protect the resident.

Full compliance with the standard was determined by the following:
Auditors reviewed critical incident report form (blank); documentation of risk of imminent sexual abuse nonoccurrence from May 1, 2014 to April 30, 2015; housing unit placement form (blank); documentation of housing unit placement based on risk of imminent sexual abuse nonoccurrence from May 1, 2014 to April 30, 2015; isolation activity log (blank); documentation of isolation nonoccurrence from May 1, 2014 to April 30, 2015.

Standard 115.363 Reporting to other confinement facilities

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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.

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

(c) The agency shall document that it has provided such notification.

(d) The facility head or agency office that receives such notification shall ensure that the allegation is investigated in accordance with these standards.

Full compliance with the standard was determined by the following:

Auditors reviewed Reporting to other confinement facilities form (blank); documentation of nonoccurrence of "receiving an allegation from another facility" between May 1, 2014 and April 30, 2015;

Statement from Yolanda Byrdsong, Campus Administrator, that Vacca Campus had no allegations reported of sexual abuse of residents while confined at another facility in the last 12 months.

Standard 115.364 Staff first responder duties

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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

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

(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.

Full compliance with the standard was determined by the following:
Auditors reviewed staff receipt of PREA training; a checklist of responsibilities for first responders; guidelines for first responders; staff interviews.

Standard 115.365 Coordinated response

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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.

Full compliance with the standard was determined by the following:
Auditors reviewed the Coordinated response plan

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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**.**

(b) Nothing in this standard shall restrict the entering into or renewal of agreements that govern:

(1) The conduct of the disciplinary process, as long as such agreements are not inconsistent with the provisions of Standard 115.372 and 115.376; or

(2) Whether a no-contact assignment that is imposed pending the outcome of an investigation shall be expunged from or retained in the staff member's personnel file following a determination that the allegation of sexual abuse is not substantiated.

Full compliance with the standard was determined by the following:
Alabama DYS is not involved in collective bargaining; as a state entity, they retain the ability to move or suspend an employee if they are under investigation for a policy violation, ie sexual misconduct.

Standard 115.367 Agency protection against retaliation

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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.

(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.

(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 beyond 90 days if the initial monitoring indicates a continuing need.

(d) In the case of residents, such monitoring shall also include periodic status checks.

(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.

(f) An agency's obligation to monitor shall terminate if the agency determines that the allegation is unfounded.

Full compliance with the standard was determined by the following:
Auditors reviewed Policy 1.29 and Policy 13.8.1 (PREA Policy)
Documentation that there has been no occurrence of housing unit placement based on retaliation nor occurrence of protections against retaliation between May 1, 2014 and April 30, 2015.
Reviewed blank form "Protections against retaliation"
Documentation that there has been no occurrence of the need for emotional support services for juveniles or staff who fear retaliation in the period from May 1, 2014 through April 30, 2015.
Reviewed blank form "Investigative outcome of allegations of sexual abuse/sexual harassment"
Documentation of Investigative outcome regarding retaliation" nonoccurrence between May 1, 2014 to April 30, 2015.

Standard 115.368 Post-allegation protective custody

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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.

Full compliance with the standard was determined by the following:
Auditors reviewed PREA policy; documentation that there has been no use of segregated housing to protect juveniles from sexual abuse/sexual harassment from May 1, 2014 to April 30, 2015. Reviewed a blank housing unit placement form, and blank Isolation activity log.

Standard 115.371 Criminal and administrative agency investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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.
(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.
(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.

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

(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.

(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.

(g) Administrative investigations:

(1) Shall include an effort to determine whether staff actions or failures to act contributed to the abuse; &

(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.

(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.

(i) Substantiated allegations of conduct that appears to be criminal shall be referred for prosecution.

(j) The agency shall retain all written reports referenced in paragraphs (g) and (h) of this section 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.

(k) The departure of the alleged abuser or victim from the employment or control of the facility or agency shall not provide a basis for terminating an investigation.

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

(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.

Full compliance with the standard was determined by the following:
Auditors reviewed PREA Policy; Policy 1.29
Reviewed a flowchart indicating the process for investigating sexual assault allegations;
Reviewed documentation of investigative outcome (unfounded) for an incident occurring May 2014; reviewed EVAWI certificate for investigator, Certificate from PREA resource center for Investigator; Certificate of training for participation in the Alabama Attorney General's 2013 Law enforcement summit, Alabama Department of Corrections training "Investigation Sexual Misconduct: Training for investigators, and training by Alabama Coalition against sexual violence on Sexual Assault Survivor Advocacy Training.

Standard 115.372 Evidentiary standard for administrative investigations

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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.

Full compliance with the standard was determined by the following:
Auditors reviewed PREA Policy and Policy 1.29
Reviewed documentation that there had been no notice of dismissal during the period May 1, 2014 to April 30, 2015.

Standard 115.373 Reporting to residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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.
(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.
(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.
(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**.**

(e) All such notifications or attempted notifications shall be documented.
(f) An agency's obligation to report under this standard shall terminate if the resident is released from the agency's custody.

Full compliance with the standard was determined by the following;
Auditors reviewed PREA Policy; Process flowchart for investigating sexual assault allegations; documentation of an occurrence of an allegation requiring reporting to a juvenile during May 2014; documentation of the investigative outcome of allegations of sexual abuse/assault/harassment; blank form "Juvenile Notification of Investigative Outcome".

Standard 115.376 Disciplinary sanctions for staff

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(a) Staff shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse or sexual harassment policies.

(b) Termination shall be the presumptive disciplinary sanction for staff who have engaged in sexual abuse.

(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.

(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.

Full compliance with the standard was determined by the following:
Auditors reviewed PREA policy; Policy 1.29
Documentation that there has been no occurrence of disciplinary sanctions for violating sexual abuse/harassment policies during the period May 1, 2014 to April 30, 2015; reviewed documentation there has been no occurrence of staff termination for violating sexual abuse/harassment policies.

Standard 115.377 Corrective action for contractors and volunteers

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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.

(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.

Full compliance with the standard was determined by the following:
Auditors reviewed PREA policy; documentation of PREA training for volunteers and contractors; documentation that there has been no occurrence of contractor/volunteer violation of PREA; blank "Critical Incident Report" form.
Statement from Yolanda Byrdsong, Campus Administrator, that no volunteer/contractor services were postponed or terminated for violations of PREA related allegations/investigations in the past 12 months.

Standard 115.378 Disciplinary sanctions for residents

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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.

(b) Any disciplinary sanctions shall be commensurate with the nature and circumstances of the abuse committed, the resident's disciplinary history, and the sanctions imposed for comparable offenses by other residents with similar histories. In the event a disciplinary sanction results in 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.

(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.

(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.

(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.

(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.

(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.

Full compliance with the standard was determined by the following:
Auditors reviewed the PREA policy and the Juvenile Handbook; a statement from Alicia Faire that there have been no occurrences of juvenile-on-juvenile sexual abuse from the period of May 1, 2014 to April 30, 2015; blank copies of the Critical Incident Forms; Student Disciplinary Report and Student Disciplinary Hearing Report; Housing Unit Placement form; Administrative Investigative Outcome Report; blank Form 115.371 for reporting investigative outcome of allegations of sexual abuse/harassement.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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.

(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.

(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.

(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.

Full compliance with the standard was determined by the following;
Auditors reviewed PREA policy; a statement by Alicia Faire that there had been no occurrence of "history of prior victimization" from the period May 1, 2014 to April 30, 2015; sample copies of intake screening results on residents; statement from Alicia Faire that there had been no Release of Information due to an occurrence of sexual abuse/harassment in the aforementioned time; copies of staff receipt of PREA training and copies of contract medical and mental health receipt of PREA training, interviews with medical staff.

Standard 115.382 Access to emergency medical and mental health services

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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.

(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.

(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.

(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

Full compliance with the standard was determined by the following:

Auditors reviewed Policy 13.8.1 PREA policy; the Cooperative agreement between Alabama DYS and The Children's Hospital of Alabama to provide victim assistance and counseling services; first responders checklist; Staff receipt acknowledging PREA training; Victim advocates receipt acknowledging PREA training; statement from Alicia Faire that no occurrence of sexual abuse had occurred from May 1, 2014 to April 30, 2015; blank copy of "Consent to Treatment" form.

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

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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.

(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.

(c) The facility shall provide such victims with medical and mental health services consistent with the community level of care.

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

(e) If pregnancy results from conduct specified in paragraph (d) of this section, such victims shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services.

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

(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.

(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.

Full compliance with the standard was determined by the following:
Auditors reviewed a statement from Alicia Faire that there had been no occurrence of sexual abuse/harassment from May 1, 2014 to April 30, 2015; MOA with the Children's Hospital of Alabama.

Standard 115.386 Sexual abuse incident reviews

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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.

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

(c) The review team shall include upper- level management officials, with input from line supervisors, investigators, and medical or

mental health practitioners

(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.

(e) The facility shall implement the recommendations for improvement, or document its reasons for not doing so.

Full compliance with the standard was determined by the following:
Auditors reviewed the PREA Policy; blank copy of "Critical incident report" form; "Critical incident initial debriefing" form; "Critical incident two-week follow up report" form; a statement from Alicia Faire that no occurrences of sexual abuse/harassment had occurred from the period May 1, 2014 to April 30, 2015.

Standard 115.387 Data collection

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(a) and (c) 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. 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

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

(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.

(e) The agency also shall obtain incident- based and aggregated data from every private facility with which it contracts for the confinement of its residents. (N/A if agency does not contract for the confinement of its residents)

(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. (N/A if DOJ has not requested agency data)

Full compliance with the standard was determined by the following:

Auditors reviewed blank copy of Survey of sexual victimization form; statement from Alicia Faire that there had been no occurrence of allegations of sexual abuse in the period from May 1, 2014 to April 30, 2015; Survey of sexual violence report from 2012; 2013 survey of sexual victimization summary form; annual PREA data review

Standard 115.388 Data review for corrective action

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(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 prepare an annual report if its findings and corrective actions for each facility, as well as the agency as a whole.

(b) Such report shall include a comparison of the current year's data and corrective actions with those from prior years and shall provide an assessment of the agency's progress in addressing sexual abuse.

(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.

(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 material redacted.

Full compliance with the standard was determined by the following:
Auditors reviewed the PREA policy; statement from Alicia Faire that there has been no occurrence of sexual abuse/harassment from the period May 1, 2014 to April 30, 2015; 2014 annual data report; annual PREA data report

Standard 115.389 Data storage, publication, and destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

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

☐ Does Not Meet Standard (requires corrective action)

Auditor 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.

The standard states:

(a) The agency shall ensure that data collected pursuant to § 115.387 are securely retained.

(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.

(c) Before making aggregated sexual abuse data publicly available, the agency shall remove all personal identifiers.

(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.

Full compliance with the standard was determined by the following:
Auditors reviewed records retention policy statement; ADYS Aggregated sexual abuse data for 2013.

AUDITOR CERTIFICATION

I certify that:

☒ The contents of this report are accurate to the best of my knowledge.

☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and

☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Dan McGehee July 30, 2015

Auditor Signature Date