Prison Rape Elimination Act (PREA) Audit Report
Juvenile Facilities

☐ **Interim** ☒ **Final**

Date of Interim Audit Report: 12/12/2021 ☐ **N/A**
If no Interim Audit Report, select N/A
Date of Final Audit Report: 05/16/2022

Auditor Information			
Name: Latera Davis		**Email:** laterad@yahoo.com	
Company Name: Just4Consultants LLC			
Mailing Address: PO Box 1105		**City, State, Zip:** Grayson, GA 30017	
Telephone: 404-457-8953		**Date of Facility Visit:** October 27-28, 2021	
Agency Information			
Name of Agency: Vivant Behavioral Healthcare			
Governing Authority or Parent Agency *(If Applicable):* Vivant Behavioral Healthcare			
Address: 1131 Eagletree Lane		**City, State, Zip:** Huntsville, AL 35801	
Mailing Address: 1131 Eagletree Lane		**City, State, Zip:** Huntsville, AL 35801	
The Agency Is:	☐ Military	☒ Private for Profit	☐ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal
Agency Website with PREA Information:			
Agency Chief Executive Officer			
Name: Tom Kenny, CEO			
Email: Tom.Kenny@vivantbh.com		**Telephone:** 928-772-4131	
Agency-Wide PREA Coordinator			
Name: Kimberly Nicholson			
Email: Kimberly.Nicholson@vivantbh.com		**Telephone:** 855-955-3070	
PREA Coordinator Reports to:		**Number of Compliance Managers who report to the PREA Coordinator:**	

Marianne Birmingham		15	
Facility Information			
Name of Facility: Woodward Academy			
Physical Address: 1251 334th St.		**City, State, Zip:** Woodward, Iowa 50276	
Mailing Address: SAA		**City, State, Zip:** SAA	
The Facility Is:	☐ Military	☒ Private for Profit	☒ Private not for Profit
☐ Municipal	☐ County	☐ State	☐ Federal
Facility Website with PREA Information: Woodward Academy (wwacademy.com)			
Has the facility been accredited within the past 3 years? ☒ Yes ☐ No			
If the facility has been accredited within the past 3 years, select the accrediting organization(s) – select all that apply (N/A if the facility has not been accredited within the past 3 years): ☐ ACA ☐ NCCHC ☐ CALEA ☒ Other (please name or describe: The Joint Commission (TJC) ☐ N/A			
If the facility has completed any internal or external audits other than those that resulted in accreditation, please describe: N/A			
Facility Administrator/Superintendent/Director			
Name: Shawn Hollenkamp, Executive Director			
Email: Shawn.Hollenkamp@wwacademy.com		**Telephone:** 515-438-3488	
Facility PREA Compliance Manager			
Name: Joel Porter			
Email: Joel.Porter@wwacademy.com		**Telephone:** 515-438-3538	
Facility Health Service Administrator ☐ N/A			
Name: Heather Hanson			

Email: Heather.Hanson@wwacademy.com	**Telephone:** 515-438-3693

Facility Characteristics	
Designated Facility Capacity:	264
Current Population of Facility:	122
Average daily population for the past 12 months:	173
Has the facility been over capacity at any point in the past 12 months?	☐ Yes ☒ No
Which population(s) does the facility hold?	☐ Females ☐ Males ☒ Both Females and Males
Age range of population:	12-18 YOA
Average length of stay or time under supervision	Community Residential (4-12 months) Long Term (12-24 months)
Facility security levels/resident custody levels	Staff Secure

Number of residents admitted to facility during the past 12 months	219
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *72 hours or more*:	219
Number of residents admitted to facility during the past 12 months whose length of stay in the facility was for *10 days or more:*	219
Does the audited facility hold residents for one or more other agencies (e.g., a State correctional agency, U.S. Marshals Service, Bureau of Prisons, U.S. Immigration and Customs Enforcement)?	☐ Yes ☒ No
Select all other agencies for which the audited facility holds residents: Select all that apply (N/A if the audited facility does not hold residents for any other agency or agencies):	☐ Federal Bureau of Prisons ☐ U.S. Marshals Service ☐ U.S. Immigration and Customs Enforcement ☐ Bureau of Indian Affairs ☐ U.S. Military branch ☐ State or Territorial correctional agency ☐ County correctional or detention agency ☐ Judicial district correctional or detention facility ☐ City or municipal correctional or detention facility (e.g., police lockup or city jail) ☐ Private corrections or detention provider ☐ Other - please name or describe: Click or tap here to enter text. ☒ N/A
Number of staff currently employed by the facility who may have contact with residents:	215
Number of staff hired by the facility during the past 12 months who may have contact with residents:	120

Number of contracts in the past 12 months for services with contractors who may have contact with residents:	12
Number of individual contractors who have contact with residents, currently authorized to enter the facility:	2
Number of volunteers who have contact with residents, currently authorized to enter the facility:	13
Physical Plant	
Number of buildings: **Auditors should count all buildings that are part of the facility, whether residents are formally allowed to enter them or not. In situations where temporary structures have been erected (e.g., tents) the auditor should use their discretion to determine whether to include the structure in the overall count of buildings. As a general rule, if a temporary structure is regularly or routinely used to hold or house residents, or if the temporary structure is used to house or support operational functions for more than a short period of time (e.g., an emergency situation), it should be included in the overall count of buildings.**	5
Number of resident housing units: **Enter 0 if the facility does not have discrete housing units. DOJ PREA Working Group FAQ on the definition of a housing unit: How is a "housing unit" defined for the purposes of the PREA Standards? The question has been raised in particular as it relates to facilities that have adjacent or interconnected units. The most common concept of a housing unit is architectural. The generally agreed-upon definition is a space that is enclosed by physical barriers accessed through one or more doors of various types, including commercial-grade swing doors, steel sliding doors, interlocking sally port doors, etc. In addition to the primary entrance and exit, additional doors are often included to meet life safety codes. The unit contains sleeping space, sanitary facilities (including toilets, lavatories, and showers), and a dayroom or leisure space in differing configurations. Many facilities are designed with modules or pods clustered around a control room. This multiple-pod design provides the facility with certain staff efficiencies and economies of scale. At the same time, the design affords the flexibility to separately house residents of differing security levels, or who are grouped by some other operational or service scheme. Generally, the control room is enclosed by security glass, and in some cases, this allows residents to see into neighboring pods. However, observation from one unit to another is usually limited by angled site lines. In some cases, the facility has prevented this entirely by installing one-way glass. Both the architectural design and functional use of these multiple pods indicate that they are managed as distinct housing units.**	9

Number of single resident cells, rooms, or other enclosures:	0
Number of multiple occupancy cells, rooms, or other enclosures:	9 Units
Number of open bay/dorm housing units:	9
Number of segregation or isolation cells or rooms (for example, administrative, disciplinary, protective custody, etc.):	0
Does the facility have a video monitoring system, electronic surveillance system, or other monitoring technology (e.g., cameras, etc.)?	☒ Yes ☐ No
Has the facility installed or updated a video monitoring system, electronic surveillance system, or other monitoring technology in the past 12 months?	☐ Yes ☒ No

Medical and Mental Health Services and Forensic Medical Exams	
Are medical services provided on-site?	☒ Yes ☐ No
Are mental health services provided on-site?	☒ Yes ☐ No
Where are sexual assault forensic medical exams provided? Select all that apply.	☐ On-site ☒ Local hospital/clinic ☐ Rape Crisis Center ☐ Other (please name or describe:

Investigations	
Criminal Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting CRIMINAL investigations into allegations of sexual abuse or sexual harassment:	0
When the facility received allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), CRIMINAL INVESTIGATIONS are conducted by: Select all that apply.	☐ Facility investigators ☐ Agency investigators ☒ An external investigative entity
Select all external entities responsible for CRIMINAL INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for criminal investigations)	☒ Local police department ☒ Local sheriff's department ☒ State police ☐ A U.S. Department of Justice component ☒ Other (please name or describe: Child Protective Services ☐ N/A

Administrative Investigations	
Number of investigators employed by the agency and/or facility who are responsible for conducting ADMINISTRATIVE investigations into allegations of sexual abuse or sexual harassment?	2
When the facility receives allegations of sexual abuse or sexual harassment (whether staff-on-resident or resident-on-resident), ADMINISTRATIVE INVESTIGATIONS are conducted by: *Select all that apply*	☒ Facility investigators ☐ Agency investigators ☒ An external investigative entity
Select all external entities responsible for ADMINISTRATIVE INVESTIGATIONS: Select all that apply (N/A if no external entities are responsible for administrative investigations)	☒ Local police department ☒ Local sheriff's department ☐ State police ☐ A U.S. Department of Justice component ☒ Other (please name or describe: (Child Protective Services) ☐ N/A

Audit Findings

Audit Narrative (including Audit Methodology)

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

Woodward Academy, part of formerly Sequel Youth & Family Services, now Vivant Behavioral Healthcare agreed to participate in a Prison Rape Elimination Act (PREA) audit, conducted by auditor (Latera Davis).

Site Review Location: The site review for this audit took place at the Woodward Academy facility located at 1251 334th St., Woodward, Iowa, 50276. The facility is in the northern section of the state. The auditor conducted pre-audit work prior to arrival at the facility. Pre-audit work included but was not limited to review of the Pre-Audit Questionnaire (PAQ), documentation review on the agency (electronically submitted), email correspondence, and telephone calls.

A certified PREA audit was conducted at the Woodward Academy facility located in Woodward, Iowa on 10/27-10/28, 2021. It should be noted that Woodward Academy is identified as a residential treatment facility, that also has contracts to provide residential therapeutic treatment services for youth in the care and custody of various youth servicing agency. The Woodward Academy facility hereinafter may be referred to as a facility or program. It should be noted that, for the purpose of this audit report, the youth housed at the facility will be called "residents" for the duration of the report.

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

Pre-onsite Audit Phase

Posting: On 7/26/2021, the auditor provided the audit notice to the Woodward Academy facility PREA coordinator (PC), with instruction to post the required PREA Audit Notice of the upcoming audit prior to the audit for confidential communications. Photos were sent to the auditor on 8/31/2021, indicating that the facility posted the notices in English and Spanish. The auditor received photos of the timestamp posted notices, located in common areas. The auditor did not receive communication from any residents.

Pre-Audit Questionnaire (PAQ): In order to prepare for the audit process, pre-kick off email correspondence occurred with the agency's Regional Staff and facility Executive Director on 6/15/2021. As the auditor reviewed the materials provided by the facility, any outstanding documents were communicated directly with the agency PREA coordinator and facility Director. Completed documents were submitted or discussed via telephonic, email and a secured cloud site.

The Pre-Audit Questionnaire was completed and sent to the auditor as required. The completed Pre-Audit Questionnaire (PAQ) was submitted on 9/13/2021. Additional documentation received included agency policies, procedures, forms, education materials, training curriculum, organizational charts, posters, brochures and other PREA related materials were also provided. The lead auditor reviewed all the documentation submitted by the facility and prepared a list of issues based on the evidence provided.

The auditor completed a documentation review using the Pre-Audit Questionnaire (PAQ), internet search, policies and procedures review, and additional documentation provided via email correspondence; to

include both the agency and the facility policy and procedures, agency mission statement, daily population report, and schematic/layout for the facility. The auditor was provided a list of requested documents for the on-site review. As the auditor reviewed the materials provided by the facility, the content/documents were organized and any outstanding issues/concerns were addressed via telephonic and email correspondence, with the agency PREA coordinator and the site PREA Compliance Manager. It should be noted that a list of random and special categorized residents was provided during the on-site review.

Website Review: Prior to the on-site portion of the audit, the auditor conducted a website review of the Woodward Academy facility. There were several public articles discussing investigations related to allegations of abuse and neglect with the foster care youth housed at the program.

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

- Staffing Plan/Documentation of deviation for the staffing plan
- Annual Reviews
- Logs of exigent circumstances for cross gender pat down searches
- Staff training logs
- Written materials used for effective communication about PREA residents with disabilities or limited reading skills
- Documentation of staff training on PREA complaint practices for residents with disabilities
- Documentation of investigators who have completed specialized investigative training
- Documentation of mental health and medical staff that have completed specialized training
- Screening instrument used to determine risk for victimization
- Documentation of use of screening information to inform housing, bed, work, education and facility assignments with the goal of keeping separate those residents with a high risk of being sexually abusive
- Sample resident grievances (on-site will review general grievances filed)
- Resident handbook
- Documentation of notifications of abuse while confined at another facility (if applicable)
- Facility institutional plan (coordinated plan)
- Retaliation reports (all investigation files, last 12 months)
- Documentation when segregated housing was used to house residents who have alleged to have suffered sexual abuse (if applicable)
- Sample of investigations of alleged sexual abuse complaints completed by the agency
- Sample of investigations of alleged sexual abuse complaints completed by outside agency
- Sample of documentation of any substantiated or unsubstantiated complaints
- Sample of documentation of notifications
- Sample records of terminations, resignations, or other sanctions against staff—allegations of sexual abuse or sexual harassment—within the last 12 months – (may request to review more sexual harassment while on site)
- Reports of sexual abuse of residents by contractors or volunteers
- Sample records of disciplinary actions against residents for sexual conduct with staff
- Sample records of disciplinary actions against residents for sexual conduct against other residents (need substantiated abuse or harassment allegations)
- Documentation of sexual abuse incident reviews
- Sexual abuse reports
- Incident Mapping Report
- Unannounced rounds documentation
- A summary of all incidents within the past 12 months (log)

- All transgender evaluations completed in the last 12 months
- Rosters
- Notice of auditor post-English/Spanish (received)
- Residents with disabilities
- Residents who are limited English proficient (LEP)
- LGBTI residents
- Residents in segregated housing (PREA related)
- Residents who reported sexual abuse
- Residents who reported sexual victimization during risk screening
- Staff roster
- Specialized staff list
- Staff personnel documentation
- Resident documentations
- List of contractors who have contact with residents
- List of volunteers who have contact with residents
- PREA reassessments (all sexual abuse cases)

On-Site Audit Phase

Team Composition/Entrance

The audit team consisted of the auditor (Latera Davis). On 10/27/2021 at approximately 12:00 pm the auditor arrived at the facility to conduct an entrance meeting with the facility director/PREA Compliance Manager and several facilities leadership: along with beginning the on-site process (physical plant inspection and interviews).

Entrance Meeting

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

Prior to the on-site audit and upon conclusion of the entrance meeting, the auditor was provided resident and employee documentation to review. Resident and staffing lists were also provided allowing the audit team to make randomized selections of interview participants. The Woodward Academy facility direct care staff work 8-hour shifts; with three respective shifts.

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

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

Interviews: Due to COVID-19, and the need to take extra safety precautionary measures; resident and informal auditor contact during the walk through was limited. The auditor was able to have informal discussion with three youth while conducting the physical plant inspection. During the informal discussion, the youth were aware of PREA.

For the formal interviews, the auditor randomly selected names of individuals who would be interviewed, and the facility staff prepared the residents and staff members for interview in a staged manner. For all completed interviews, appropriate PREA-interview protocols were utilized, and standard advisory statements were communicated with the interviewing audit team member recording responses by hand or typed.

On the first day of the on-site audit there were 126 residents reported at the facility. Staff interviews were based on who was at the facility on the days of the audit, varying staff shifts, and positions/roles held. Over the two days being on-site, 29 interviews were conducted with staff that have specialized roles and responsibilities. It should be noted that this also included staff that have dual role responsibilities. The interviews were conducted privately in several different meeting rooms and the protocols used included but were not limited to incident review team members, mental health staff, screening staff, security first responder, agency head, staff who supervise residents in isolation, agency contract administrator, HR administrator, intake staff, PREA coordinator, intermediate or higher-level staff, facility director, medical staff, and staff who monitor for retaliation. The Woodward Academy facility did not have any approved volunteers at the facility during the audit process.

Along with the specialized staff, 12 random staff, to include a teacher were interviewed. Random staff were chosen by retrieving a list of staff from every shift, including new and more tenured staff. A teacher was also interviewed using the random staff guide. A separate list of targeted residents was provided prior to the on-site audit. A total of 15 targeted resident interviews were interviewed. There were no residents housed for the sole purpose of immigration. It was also reported that there were no residents segregated for risk of sexual victimization, which was confirmed through staff and resident interviews, as well as site review by audit team members. The interviews were conducted primarily in an empty offices or staff offices and telephonic communication.

The sampling strategy included interviewing all residents which included a selection of targeted residents within the sample of participants. Interviews were conducted using the Department of Justice (DOJ) protocols to assess the resident's knowledge of PREA and reporting mechanisms available to them at the Woodward Academy facility.

Category of Residents	Number of Interviews conducted
Random residents	20
Targeted residents	15
Total Residents Interviewed	
Breakdown of Targeted Residents Interviewed	
Residents with disabilities	0
Residents who are blind, deaf, or hard of hearing	1
Residents who are LEP	0
Residents with cognitive disabilities	2
Residents who are LGB	3
Residents who Identify as transgender or intersex	0
Residents who reported sexual abuse/harassment that occurred at the facility	4
Residents who reported sexual victimization during risk screening	5
Resident segregated housing for sexual victimization	0
Category of Staff Interviewed *** It Should Be Noted That Some Interviews Conducted Duplication of The Same Staff.	
Random Sample of Staff	12* include education

Specialized staff	25
Agency head	1
Facility director	1
PREA compliance manager	1
PREA coordinator (Vivant)	1
Total Staff Interviewed	29 (Total Interviewed)
Breakdown of Specialized Staff	
Contract administrator	0
Intermediate or higher-level staff responsible for conducting and documenting unannounced rounds	2
Medical staff	1
Mental health staff	1
Non-medical staff involved in cross gender searches (f applicable)	NA
Volunteers Who Have Contact with Residents	0
Contractors Who Have Contact Residents	1
Administrative Investigators	2
Intake	1
Staff Who Perform Risk for Victimization and Abusiveness	1
Staff Who Screen Resident in Segregated Housing	NA
Designated Staff Members Charged with Monitoring for Retaliation	1
First Responders	12* random direct care staff
Incident Review Team	2
HR Administrator	1

Site Review: The auditor conducted a comprehensive site review of the facility. Residents had access on-site and could be present. The director, assisted in escorting the auditor throughout the facility during the inspection.

During the site review, the following areas were inspected:

- Administrative offices
- Education area
- Resident Housing (9 dormitories; however, all are not in use)
- Gymnasium/Recreation
- Cafeteria-all are not in use due to COVID-19
- Clinical/Therapy offices/near Girls Unit

During the onsite inspection, it was requested that when the auditor paused to speak to a resident, for staff to please step away so the conversation may remain private. In the housing area, there are 1-3 residents per room. Each housing area has its own bathroom and shower area. The auditor noted that shower and toilet areas allow residents to shower ensuring their privacy from staff direct viewing. The auditor noted that the shower curtains also provided limited ability for staff to identify how many individuals were in the same shower at one time. The auditor requested that the facility adjust the shower curtains, so they are PREA compliant. The auditor was provided unimpeded access to all parts of the facility and all secure rooms and storage areas in the facility. The auditor spoke informally with residents and staff

during the site inspection which covered administration, education, living rooms, recreation area, dining area, programming areas, visitation areas, storage rooms, closets, etc.

The education area could have a blend of male/female residents depending on education needs. There are cameras in the hallways and in the classrooms. All classrooms have windows with multiple viewing points in the classroom area. The electrical/maintenance closets were always locked. During the onsite inspection, it was observed that there was no PREA signage in the education buildings. It is recommended that PREA posters are placed in the education buildings.

The Woodward Academy facility is a secured facility for females/males in need of specialized secure residential treatment services. The facility provides services for residents from various states. It should be noted that the facility has a unit for youth who have exhibited sexually abusive behaviors. The unit has motion alarm in the housing area. For all housing areas, the doors must remain open.

The auditor inspected facility doors, restrooms, and office areas. The areas were consistently secured and locked. The residents have access to cordless phones. It was reported that if they need to contact, they hotline they would access for a private call. During the onsite inspection the auditor observed a youth on a private call. The private call provided some level of distance from staff where conversation could not be overheard.

The auditor noted placement and coverage of video monitoring and technology, along with surveillance cameras, and reviewed for potential blind spots. Camera footage is available over a seven-day time span. There were no locations of concern identified during the tour. There were adequate staffing levels during the onsite inspection.

Community Outreach

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

Advocacy Organization	Date Received
Just Detention International (JDI)	8/23/2021
RAINN	Didn't receive response
Local Child Advocacy Center	Called Didn't receive a response

The auditor asks the advocacy organizations the following questions:

How many residents reported sexual abuse and/or sexual harassment in the last 12 months?

Have you received any reports on the facility in the last 12 months?

Documentation Review and Sampling

Documents Reviews: During the site review, documentation review included, but was not limited to the auditor review of personnel files, training records, resident intake, screening, and PREA education records; and any other related documents that covered the prior 12-month period. The documentation review process was covered by the auditor. The PAQ reported zero investigations.

Investigations Review

	Sexual Abuse		Sexual Harassment	
	Resident on Resident	Staff on Resident	Resident on Resident	Staff on Resident
Hotline	0	0	0	0
Grievance	0	0	0	0
Reports to Staff	6	6	0	0
Anonymous, 3rd party	0	0	0	0
Reports by Staff	0	0	0	0

***All allegations were unsubstantiated or unfounded.

Grievances: The Woodward Academy facility has grievance boxes located in the education and administrative area.

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

Exit Briefing

The audit team conducted an exit meeting on 10/28/2021, at which preliminary findings of the review were discussed with the facility leadership team. During the exit, the auditor provided an overview of the on-site inspection results and discussion of follow up requested information.

Post-Onsite Audit Phase

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

Communication with the Woodward Academy Director began immediately upon the conclusion of the on-site audit. Communication was ongoing, with responses provided consistently both by email and telephone. Documentation and clarification communication emails facilitated the ability to process both the Interim and Final Reports.

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

Interim Audit Report: The auditor completed entry of data into and determination of standard compliance on the Audit Compliance Tool and began writing of the Interim Report. The Interim Report included

reference to policies and procedures, agency and facility reports, and supplementary documentation provided by the facility and during the site review, supporting information gathered during site review, as well as aggregated and de-identified information regarding interviews conducted for the purposes of this audit. The auditor incorporated evidence gathered on-site and through documentation review as proof for the conclusion of whether the facility exceeded, met, or did not meet the standard of review.

Interim Audit Report Submitted: 12/12/2021

Final Audit Report: 5/15/2022

Facility Characteristics

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

Mission Statement

The mission of Woodward Academy is to provide a safe and structured environment in which our students can learn, develop and apply skills that will provide positive direction for their futures.

The core values we employ in the pursuit of this mission are reflected in "what we do around her." Around here we:

- Treat others with dignity and respect.
- Embrace diverse ideas.
- Encourage personal growth and development.
- Encourage laughter in the workplace.
- Work as a team.
-

Facility Demographics

Total positions filled: 190

Volunteer – 0 ***services not functioning at this time due to COVID-19

Contractors – 12

Facility Description

On July 10, 1995, the Woodward Academy opened as an all-male residential treatment facility for boys ages 12-18. The 1980's and 1990's saw a rise in juvenile crime across the country, and Governor Branstad wanted to address the problem. Woodward Academy was created in response to legislation passed by the Iowa Legislature calling for the establishment of rehabilitation programs for troubled youth. On that day, Woodward was one of two "boot camps" established in the state (the facility in Davenport no longer operates).

The four students and 13 staff members who started on that day had no idea that over the next two decades, Woodward Academy would become one of the best juvenile treatment facilities in the nation. Those humble beginnings have grown into a school that has a student population of 265 students and that employs 235 staff members. Every day, students receive the clinical services they deserve, are

offered an educational curriculum from certified teachers, and are given opportunities to excel in high school athletics. Although Woodward Academy is labeled a treatment facility, it operates like a private prep school where students are proud to be Knights.

The Woodward Youth Corporation (WYC), a non-profit organization, was created in 1995 to manage the day-to-day activities of Woodward Academy. One building was leased and renovated from the Woodward Resource Center, which served as the first 24-bed dormitory for students. By August of 1995, that dorm was full, and Woodward never stopped growing. In October of '95, space for a second dormitory was added and in the following January, the Academy expanded to another building and its third dormitory. In just under one year's time, Woodward Academy had four programs operating and 96 beds available for students.

The early years saw rapid growth for the Academy, but the school was still in its infancy. The staff were new, many inexperienced, and at times the primary daily focus was survival. As a result, student "buy-in" was lacking and relationships between students and staff were not solid. For the first five years, the WYC partnered with Youth Services International (YSI) and Correctional Services Corporation, whose main function was to help manage Woodward Academy.

Continued Expansion:

In 2002, a fifth dorm was added that brought the student census up to 120 students. An additional dorm was added each of the next two years and by August 2004, the Academy's capacity had grown to 168 students.

An increase in students also required an expansion of facilities. In 2000, the decision was made to create an education center. At a cost of just over $700,000, the new school building opened in late 2002 and moved the crowded, partitioned classrooms from the weight room into a building with 11 classrooms and a gymnasium. The expanded space was only the beginning for an education program that now has 25 classrooms, a computer lab, 3 conference rooms, and offices within 4 buildings dedication to schooling.

The best part about growing as a school has been the continued expansion in other areas as well. In 2007, the student moving company, Knights on the Move, started operation, allowing students to earn a wage while on campus. Additional student jobs have been added throughout the years and now include custodial work in the schools and administrative buildings, and during the summer a landscaping crew helps mow and maintain the campus grounds. The Academy's athletic facilities have grown considerably and now include a new baseball field (2012), powerlifting weight room updated with collegiate equipment (2012), and a football field and track (updated in 2013). In July 2017 we started accepting girls as the new girl's dorm opened on Pathfinder Hall.

The first 20 years in Woodward Academy's history has seen remarkable growth. More importantly, the first 20 years has seen Woodward Academy provide remarkable services and opportunities to at-risk youth who are often marginalized by society. As a school, Woodward Academy has proven that when expectations are set, and resources provided to succeed, students from all walks of life can excel. At Woodward Academy, success is a norm, and it will only expand as the school moves into its next 20 years.

<u>Services Offered</u>
Behavioral Health Intervention Service Provider
Day School Services
Highly Structured Community Residential Services
Sexual Offender Program
Individual/Family Counseling Services

Mental Health Therapy Services
Community Based Services
Education (Regular Ed.& Special Ed. Services)

Summary of Audit Findings

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

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

Standards Exceeded: TBD

Number of Standards Exceeded: 0
List of Standards Exceeded:

Standards Met:

Number of Standards Met: 43
List of Standards Met:

Prevention and Planning

- 115.311 Zero Tolerance of sexual abuse and sexual harassment; PREA Coordinator
- 115.312 Contracting with other entities for the confinement of residents
- 115.313 Supervision and monitoring
- 115.315 Limits to cross-gender viewing and searches
- 115.316 Residents with disabilities and residents who are limited English proficient
- 115.317 Hiring and Promotion Decisions
- 115.318 Upgrades to facilities and technology

Responsive Planning

- 115.321 Evidence Protocol and forensic medical examinations
- 115.322 Policies to ensure referrals of allegations for investigations

Training and Education

- 115.331 Employee Training
- 115.332 Volunteer and Contractor Training
- 115.333 Resident Education
- 115.334 Specialized training: Investigations
- 115.335 Specialized training: Medical and mental health care

Screening and Risk of Sexual Victimization and Abusiveness

- 115.341 Obtaining information from residents
- 115.342 Placement of residents in housing, bed, facility, education, and work assignments

Reporting

- 115.351 Resident Reporting
- 115.352 Exhaustion of administrative remedies
- 115.353 Resident access to outside support services and legal representation
- 115.354 Third-party reporting

Official Response Following a Resident Report

- 115.361 Staff and agency reporting duties

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

Investigation

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

Discipline

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

Medical and Mental Care

- 115.381 Medical and mental health screenings; history of sexual abuse
- 115.382 Access to emergency medical and mental health services
- 115.383 Ongoing medical and mental health care for sexual abuse victims and abusers
-

Data Collection and Review

- 115.386 Sexual abuse incident reviews
- 115.387 Data Collection
- 115.388 Data Review for Corrective Action
- 115.389 Data Storage, Publication, and Destruction

Audits and Corrective Action

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

Standards Not Met

Number of Standards Not Met: 0
List of Standards Not Met: NA

Summary of Corrective Action (if any): It should be noted that there were multiple policy updates required that were addressed during the pre and post onsite audit phase. The policies were updated to represent the current umbrella agency PREA related policies and procedures.

It should also be noted that during the pre and post audit phase, the umbrella agency changed. Due to the changes, there are additional agency level interviews that will have to be completed.

Pending areas of corrective action:

The following items are needed to determine compliance:

115.311: Update organization chart to include the role of the PREA Coordinator/PREA Compliance Manager.

115.313: 12-month sample of senior leadership rounds

Annual Report
Memo stating that there were no deviations to the staffing plan

115.316: PREA brochures/education in another language.
Updated staff training curriculum and verification that staff received updated training

115.317: Sample of 5 year or annual background check
Background checks for contracted staff

115:321: Certificate for internal investigator staff that they completed the NIC Specialized Training for Investigators

115.322: Certificate for internal investigator staff that they completed the NIC Specialized Training for Investigators

115.331: The current PREA Training does not contain all of the required elements. Need to update the training and conduct a refresher with all staff. Provide proof of the updated training along with the refresher. Required elements:

- Agency's zero-tolerance policy for sexual abuse and sexual harassment.
- How to fulfill their responsibility under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures.
- The right of residents to be free from sexual abuse and sexual harassment.
- The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment.
- The dynamics of sexual abuse a sexual harassment in confinement.
- The common reactions of sexual abuse and sexual harassment victims.
- How to detect and respond to signs of threatened and actual sexual abuse.
- How to avoid inappropriate relationships with residents.
- How to communicate effective and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender-nonconforming residents; and
- How to comply with relevant laws related to mandatory reporting of sexual abuse with outside authorities.
    - 115.331 (b). Do you have any gender specific training?
    - 115.331 (c). Need verification that existing staff completed PREA refresher training prior to the onsite audit date.

115.332: Need verification that contracted staff and volunteers received PREA Training? Provide a copy of the training curriculum for volunteers and contractors.

115.333: Upload the resident PREA video to the shared site
Need PREA Brochures in Spanish/English

115.334: The facility shall provide a copy of the specialized training certificates for onsite investigators.

115.335: The facility shall provide a copy of the specialized training certificates for onsite medical and mental health staff.

115.351: Need a sample of grievances filed over the last 12 months to include all grievances associated with sexual abuse or sexual harassment.

115.352: Need a sample of grievances filed over the last 12 months to include all grievances associated with sexual abuse or sexual harassment.

115.353: Recommendation: The youth are not aware of access for victim services or an advocate. One way to remedy this is to update the *Student Orientation* packet and add numbers for local or national victim advocate or rape crisis organization. While the facility had posted material, the above is recommendation to reiterate the process.

115.366: Write a memo that states there was no collective bargaining.

115.367: Provide a copy of the monitoring retaliation that occurred on all allegations of sexual abuse. If monitoring didn't occur, we will have to have a corrective action for a period of time. If there have been any new allegations since I was onsite, please ensure that monitoring occurs.

115.371: Upon review of the allegations of sexual abuse there were several areas of concern identified. At the time of the onsite audit, the facility did not have a staff member who had completed the required specialized investigator training. It was also determined that not all of the allegations contained all of the required documents to review the investigation. It appears that there was a change of practice at the facility and the allegations investigated in the last 6 months contained the required elements per policy for investigation. The allegations of sexual abuse are referred to local law enforcement, it is recommended that staff obtain a copy or response to whether local law enforcement will or has investigated. The auditor will monitor allegations of sexual abuse and response to investigate during the corrective action phase.

115.372: While most allegations of sexual abuse were investigated using the proper protocols the auditor recommends that the necessary facility staff completed the specialized training for investigators to understand the scope of preponderance of evidence and how to properly handle evidence.

115.373: There were several areas of concern related to notification. It should also be noted that the facility did not have a policy in place to address notification. Upon review of 11 allegations of sexual abuse in the last 12 months. Approximately half of the allegations involved staff. It was also identified that the facility did not consistently notify the victim of the results of the allegation. The auditor is recommending corrective action and that the staff identify a person to conduct the notifications. It is also recommended that the staff provide proof of the notification for any allegations of sexual abuse during the corrective action phase.

115.381: What documentation is used for the follow up with medical and mental health after the initial assessment and the resident indicates a prior history of victimization. I know that a reassessment is conducted but is there a treatment plan which shows services offered as a follow up? If so, please upload a sample of 10 treatment plans for residents with prior hx of victimization and 10 residents with prior history of perpetration.

115.382: For the allegations of sexual abuse that occurred in the last 12 months, provide verification that the residents were offered follow up medical and mental health services. This is an automatic and not contingent on the results of the allegation. If services were not offered, we will need to monitor any pending or upcoming allegations to ensure compliance with the standard.

115.383: For the allegations of sexual abuse that occurred in the last 12 months, provide verification that the residents were offered follow up medical and mental health services. This is an automatic and not contingent on the results of the allegation. If services were not offered, we will need to monitor any pending or upcoming allegations to ensure compliance with the standard.

115.387: Provide a copy of the agency annual report.

115.388: Provide a copy of the agency annual report.

115.389: Provide a copy of the agency annual report.

Onsite Inspection:

- Place PREA Posters in the education area.
- Update shower curtains to be PREA compliant-Action Item Completed.
- Signage for the local child advocacy for emotional support and advocacy services.

PREVENTION PLANNING

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

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

115.311 (a)

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

115.311 (b)

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

115.311 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents: (Policies, directives, forms, files, records, etc.)
   a. Pre-Audit Questionnaire (PAQ)
   b. Organizational Chart
   c. Policy: Child Abuse
2. Interviews:
   a. PREA coordinator (PC)
   b. PREA compliance manager (PCM)
   c. Contract administrator
   d. Executive Director

Findings (By Provision):

115.311 (a). According to the PAQ, the Woodward Academy facility, reported that the agency has a written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment in facilities it operates directly or under contract. The facility reported having a policy outlining how it will implement the agency's approach to prevent, detect, and respond to sexual abuse and sexual harassment. The agency's policies include definitions of prohibited behaviors regarding sexual abuse and sexual harassment.

When the audit was initiated, the Woodward Academy facility is governed by Sequel Youth and Family Services. However, during the pre-onsite audit phase the governing company was transferred to Vivant Behavioral Healthcare. The Woodward Academy facility has policies and standards that govern the Prison Rape Elimination Act. Policy & Procedures*, Zero Tolerance*, RR-PREA.311, *(p.1)*, states that:

> The facility has a zero-tolerance policy related to sexual abuse or sexual harassment of a resident and will cooperate in the investigation and prosecution of anyone involved in a sexual abuse and/or sexual harassment of a resident. The facility staff will implement and understand the approach to take when preventing, detecting, and responding to sexual abuse and sexual harassment. The primary responsibility of all facility employees is resident safety. This policy shall be followed in conjunction with all Federal and State mandatory reporting requirements.

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

115.311 (b). As reported in the PAQ, the agency employs or designates an upper-level, agency-side PREA coordinator. The Woodward Academy facility employs an upper level, agency wide PREA coordinator. During the audit process, there was an agency change. The Woodward Academy was under the umbrella of a different agency (Vivant). The interim Agency PREA Coordinator reported that they have enough time to manage all of the PREA related responsibilities. It was further reported that there is one designated PREA compliance manager at each facility that is required to comply with PREA. The agency's PREA coordinator acts as a resource to PREA compliance managers, answering questions and directing them to material resources. The PREA coordinator also provide policy oversight and proactively tracks routine requirements around reporting, data collection, survey corrective actions, etc. by reaching out to the PREA compliance managers to gain progress reports.

The interviewed PREA coordinator and PREA compliance manager reported that they have adequate time to complete their duties.

Risk assessment protocols are followed to identify the issue's risk and likelihood of spread/reoccurrence. Based on the risk and likelihood of spread, the PREA coordinator may (a) become directly involved in action planning solutions, or (b) the PREA coordinator may not become directly involved and instead confirm the facility is aware of required protocols for corrective actions. The PREA coordinator ensures that the facility's PREA compliance manager and operations leadership are aware of their duty to act and maintain the safety and integrity of the PREA program. The PREA coordinator participates in the agency's annual risk assessment and work planning process, ensuring PREA risks are considered in agency-wide planning.

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

115.311 (c). According to the PAQ, the Woodward Academy facility has a designated PREA compliance manager. The Woodward Academy facility provided an organizational chart outlining the setup of the organization and the role of the PREA Compliance Manager.

Interviews

PREA Compliance Manager: The interviewed PREA Compliance Manager reported that they have time to complete all duties assigned as needed. Typically, there is another full-time employee in the department who would be able to assist with other duties. The facilities efforts to comply with PREA standards are done through annual PREA refresher trainings, and PREA standards are monitored and reviewed to make sure compliance. If there are any identified issues the PCM would present the issue to the management team, cite the PREA standards that were out of compliance, and come up with a corrective action plant to get in compliance.

Documentation reviewed for compliance

Organization Chart

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

Corrective Action:
The following items are pending and will need to be reviewed to determine compliance:

- Update organization chart to include the role of the PREA Coordinator/PREA Compliance Manager. The updated organizational chart was provided. No further action is needed.

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

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

115.312 (a)

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

115.312 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents: (Policies, directives, forms, files, records, etc.):
   a. Pre-Audit Questionnaire (PAQ)
   b. Copy of Confinement for Contracts

Findings (By Provision):

115.312 (a). The Woodward Academy facility does not have the authority to contract with other entities for the confinement of residents. The Pre-Audit Questionnaire (PAQ) indicated that the agency has not entered into or renewal of a contract for the confinement of residents on or after August 20, 2012, or since the last PREA audit. However, upon further review, the Woodward Academy is the contracted facility and does not subcontract out any services.

Documentation Reviewed

Copy of Confinement for Contracts

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

115.312 (b). As reported in the PAQ, the agency/facility does not have any contracts to monitor.

Interviews

The facility does not have a contract administrator,

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

Corrective Action:

No corrective action is warranted.

Standard 115.313: Supervision and monitoring

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

115.313 (a)

- Does the facility have a documented staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect residents against sexual abuse?
- ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Generally accepted juvenile detention and correctional/secure residential practices? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any judicial findings of inadequacy? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from Federal investigative agencies? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any findings of inadequacy from internal or external oversight bodies? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: All components of the facility's physical plant (including "blind-spots" or areas where staff or residents may be isolated)? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The composition of the resident population? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: The number and placement of supervisory staff? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Institution facilities occurring on a particular shift? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration: Any applicable State or local laws, regulations, or standards? ☒ Yes ☐ No

- In calculating adequate staffing levels and determining the need for video monitoring, does the staffing plan take into consideration the prevalence of substantiated and unsubstantiated incidents of sexual abuse? ☒ Yes ☐ No

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

115.313 (b)

- Does the agency comply with the staffing plan except during limited and discrete exigent circumstances? ☒ Yes ☐ No

- In circumstances where the staffing plan is not complied with, does the facility document all deviations from the plan? (N/A if no deviations from staffing plan.) ☒ Yes ☐ No ☐ NA

115.313 (c)

- Does the facility maintain staff ratios of a minimum of 1:8 during resident waking hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.)
  ☒ Yes ☐ No ☐ NA

- Does the facility maintain staff ratios of a minimum of 1:16 during resident sleeping hours, except during limited and discrete exigent circumstances? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) ☒ Yes ☐ No ☐ NA

- Does the facility fully document any limited and discrete exigent circumstances during which the facility did not maintain staff ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) ☒ Yes ☐ No ☐ NA

- Does the facility ensure only security staff are included when calculating these ratios? (N/A if the facility is not a secure juvenile facility per the PREA standards definition of “secure”.) ☒ Yes ☐ No ☐ NA

- Is the facility obligated by law, regulation, or judicial consent decree to maintain the staffing ratios set forth in this paragraph? ☒ Yes ☐ No

115.313 (d)

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

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: Prevailing staffing patterns? ☒ Yes ☐ No

- In the past 12 months, has the facility, in consultation with the agency PREA Coordinator, assessed, determined, and documented whether adjustments are needed to: The facility's deployment of video monitoring systems and other monitoring technologies? ☒ Yes ☐ No

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

115.313 (e)

- Has the facility implemented a policy and practice of having intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Is this policy and practice implemented for night shifts as well as day shifts? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

- Does the facility have a policy prohibiting staff from alerting other staff members that these supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility? (N/A for non-secure facilities) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

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

c. Pre-Audit Questionnaire (PAQ)
a. Policy:
    - PREA Staffing Plan
    - PREA Zero Tolerance
b. Annual Staffing Plan (dated 4/29/2022)
c. Senior Leadership Observation Rounds (12-month sample)
d. Memo: Deviations to the Staffing Plan (Dated 2/17/2022)

2. Interviews:
    a. Executive Director
    b. PREA compliance manager
    c. Intermediate or higher-level staff - 2

Findings (By Provision):

115.313 (a). The facility indicated in their responses to the Pre-Audit Questionnaire that the agency ensures that each facility it operates develops, implements, and documents a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect residents against sexual abuse. In calculating these adequate staffing levels and determining the need for video monitoring, facilities shall take into consideration all relevant factors. It further indicated that the average daily number of residents since the last PREA audit is 173. Additionally, the average daily number of residents in which the staffing plan was predicted is 173. A memo was provided indicating that DHS approved for the facility to go from a 1:4 staff to student ratio to a 1:5 staff to student ratio due to staffing shortages exacerbated by COVID 19 outbreaks. This deviation from the staffing plan did not prevent Woodward Academy staff from providing appropriate supervision to protect clients from sexual abuse.

Policy & Procedures, PREA Staffing Plan, states that "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. The facility leadership team is required to review, adjust, and complete the staffing report annually" (*p. 1*). The policy further states that "facility shall comply with the staffing plan except during limited and discrete exigent circumstances and shall fully document deviations from the plan during such circumstances" (p. 1). It further states that any deviations and exigent circumstances will be documented. The policy governs that the annual plan must be reviewed annually and include:

- Generally accepted juvenile detention and correctional/secure residential practices.
- Judicial findings of inadequacy.
- Federal findings of inadequacy.
- Any findings of inadequacy from internal or external oversight bodies.
- Composition of resident population.
- All components of the facilities physical plant (including "blind spots" or areas where staff or residents may be isolated).
- Composition of the resident population.
- Number and placement of supervisory staff.
- Institution facilities occurring on a particular shift.
- Any applicable State or local laws, regulations, or standards.
- Prevalence of substantiated incidents of sexual abuse.
- Any other relevant factors.

During the onsite inspection the auditor observed that the staff to resident ratios exceeded the PREA requirements. Staff were adequately placed where the residents were located.

Interviews

Executive Director: The interviewed Executive Director (ED) reported that staffing levels to protect residents against sexual abuse is considered in the plan. This is done by rounds completed numerous times a week on all shifts, outside the count supervisors on AM and PM shifts, two supervisors work the overnight shifts and conduct rounds; video monitoring is a part of the plan; and staffing plan is documented using the Iowa code 441 chapter 114. When assessing staffing plans all of the above is taken into consideration. Compliance of the staffing plan is checked by formal rounds, video compliance, supervisors' informal rounds, quality assurance and compliance director review, and corporate quality and compliance.

PREA Compliance Manager: The PCM confirmed the above staffing plan protocol. It was further reported that all dorms have a ratio of 1 staff to 4 students awake, and 1 staff to 16 students asleep. Video monitoring has been installed on all units. Extra staff can be added if there is a need.

Documentation Reviewed

Memo: Deviations to the Staffing Plan (Dated 2/7/2022)

Staffing Plan (Dated 4/29/22)

Corrective Action:

The facility did not have a staffing plant the met all of the requirements of the PREA standards. The staffing plan was developed during the post audit phase and now meets the requirements.

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

115.313 (b). As reported in the PAQ, the Woodward Academy facility has not deviated from the staffing plan. The Woodward Academy facility operates a staffing plan that meets the PREA ratio standards. The current staffing ratios for the Woodward Academy facility is 1:5-day hours and 1:16 sleeping hours. The Woodward Academy facility provided documentation of the staffing shift/roster.

Interviews

Executive Director (ED): The interviewed ED reported that facility would document any instances of noncompliance with the staffing plan, along with an explanation of noncompliance. However, always meets the requirements of the staffing plan.

Documentation Reviewed

Memo: Deviations to the Staffing Plan (Dated 2/7/2022)

Staffing Plan (Dated 4/29/22)

Corrective Action:

The facility did not have a staffing plant the met all of the requirements of the PREA standards. The staffing plan was developed during the post audit phase and now meets the requirements.

115.313 (c). As reported in the PAQ, the Woodward Academy facility met staffing ratios by maintaining the staffing ratios of minimum 1:8 during resident waking hours and 1:16 during resident sleeping hours. The facility has not deviated from the staff ratios of 1:8 during waking hours and 1:16 during resident sleeping hours. Policy & Procedures, *PREA Staffing Plan,* states that "the 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". It further states that "the facility keeps a ratio of staff to residents at all times. The ratio is 4 residents for every 1 staff member during waking hours and 16 residents for every 1 staff member during sleeping hours". (p. 1).

Documentation Reviewed

Deviations from staffing Plan Memo

Interviews

Executive Director (ED): The interviewed ED stated that the facility is obligated by state law to (IAC: 114.8 (2) to meet the student/staff ratios under program services. The facility maintains appropriate staffing ratios by conducting formal rounds, video compliance, supervisor informal rounds, quality assurance and compliance director review, and corporate quality and compliance.

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

115.313 (d). As reported in the PAQ, the facility requires that the intermediate-level or higher-level staff conduct unnanounced rounds. According to the Woodward Academy Facility Staffing Plan (dated 5/21/2021), there have been no known changes to the staffing numbers within the last 12 months. As reported in the PAQ, at least once a year the facility, in collaboration with the agency's PREA coordinator; reviews the staffing plan to see whether adjustments are needed to:

- The staffing plans
- Prevailing staffing patterns
- The deployment of monitoring technology; or
- The allocation of agency or facility resources to commit to the staffing plan to ensure compliance with the staffing plan.

A memo was provided indicating that DHS approved for the facility to go from a 1:4 staff to student ratio to a 1:5 staff to student ratio due to staffing shortages exacerbated by COVID 19 outbreaks. This deviation from the staffing plan did not prevent Woodward Academy staff from providing appropriate supervision to protect clients from sexual abuse.

Documents Reviewed:
Memo: Deviations to the staffing Plan (Dated 2/17/2022)

Annual Staffing Plan (Dated 4/29/2022)

Corrective Action:

The facility did not have a staffing plant the met all of the requirements of the PREA standards. The staffing plan was developed during the post audit phase and now meets the requirements.

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

115.313 (e). As reported in the PAQ, the Woodward Academy facility has a policy and practice in place where intermediate or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment. Policy and Procedure, *PREA Zero Tolerance*, states that "The facility has intermediate-level or higher-level supervisors conduct and document unannounced rounds to identify and deter staff sexual abuse and sexual harassment. This is implemented for night shifts as well as day and evening shifts. The facility prohibits staff from alerting other staff members of an unannounced round. Unannounced rounds are documented and kept in the office of the PREA Compliance Manager" (p. 4).

The auditor reviewed 17 unannounced rounds (Senior Observation *Leadership Rounds*); confirming the facility practice of conducting documented unannounced rounds.

Interviews

Two intermediate or higher-level staff members were interviewed, and reported unannounced rounds are conducted and documented. The unannounced rounds/observation rounds are completed and turned into the compliance team. It was further reported that staff are prevented from alerting each other that an unannounced round is being conducted as the staff are all visible during the rounds.

Documentation Reviewed

Senior Leadership Observation Rounds

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

Corrective Action:
The following items are pending and will need to be reviewed to determine compliance:

12-month sample of senior leadership rounds-completed

Annual staffing plan

Memo stating that there were no deviations to the staffing plan-completed

All items have been completed and there are no additional requirements needed for compliance.

Standard 115.315: Limits to cross-gender viewing and searches

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

115.315 (a)

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

115.315 (b)

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

115.315 (c)

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

- Does the facility document all cross-gender pat-down searches? ☒ Yes ☐ No

115.315 (d)

- Does the facility have policies that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No

- Does the facility have procedures that enable residents to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks? ☒ Yes ☐ No

- Does the facility require staff of the opposite gender to announce their presence when entering a resident housing unit? ☒ Yes ☐ No

- In facilities (such as group homes) that do not contain discrete housing units, does the facility require staff of the opposite gender to announce their presence when entering an area where residents are likely to be showering, performing bodily functions, or changing clothing? (N/A for facilities with discrete housing units) ☐ Yes ☐ No ☒ NA

115.315 (e)

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

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

115.315 (f)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        i. PREA Searches, Contraband, and Cross Gender Viewing
        ii. PREA Zero Tolerance
        iii. Student Searches
    c. Staff Training Records/New Hire– 52
    d. *PREA Training Curriculum*
2. Interviews:
    a. Random sample of staff -12
    b. Random sample of residents - 20

Findings (By Provision):

115.315 (a). As reported in the PAQ, the Woodward Academy facility does not conduct cross-gender strip or cross-gender visual body cavity searches of residents. In the past 12 months there have been zero reported cross-gender strip or cross gender visual body cavity searches of residents. Policy *Student Searches*, provides guidance on how the organization conducts searches. According to the policy "periodic "on person" searches of student would involve the student to be asked to turn his pockets inside out, take off shoes, and shake out hair" *(p. 1)*. Policy, *PREA Searches Contraband and Cross Gender Viewing*, states that "a resident may only be searched with significant cause and with the permission by

upper-level management, this will only be a pat down search. Residents will only be searched in a private area with two members of the same sex employee. Cross-gender strip, visual body cavity, and pat-down searches are prohibited no exigent circumstances. Residents will never be asked to remove under garments" (p. 1).

115.315 (b). The Woodward Academy facility reported in the PAQ that it does not permit cross-gender pat-down searches of residents, absent exigent circumstances. It was also reported that there were zero pat-down searches of male residents that were conducted by female staff; and zero pat down searches of male residents conducted by female staff that did not involve exigent circumstances. Policy & Procedures, *Searches, Contraband, Cross Gender Viewing,* further reiterates that, there are no exigent circumstances that would approve cross gender pat down searches (p.1).

Interviews

Random Sample of Staff: Twelve interviewed staff, representing staff from all shifts, were interviewed. The staff expressed that they are not allowed to conduct pat down searches.

Random Sample of Residents: Twenty random residents were interviewed. The residents reported that they have not been pat down searched. One resident stated that they could not recall if it was at the Woodward location and whether or not they were pat down searched upon arrival at the program.

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

115.315 (c). The facility indicated in their response to the PAQ that there is no policy that requires that all cross-gender strip searches and cross-gender visual body cavity searches are documented. The facility reported in the PAQ that there was no cross-gender strip or cross-gender visual body cavity searches conducted at the facility in the last 12 months. As previously stated, the facility prohibits cross-gender strip or cross-gender visual cavity searches.

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

115.315 (d). As indicated in the PAQ, the facility has not implemented policies and procedures that enable residents to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks, along with policies and procedures that require staff of the Policy & Procedures, *Searches, Contraband, Cross Gender Viewing*, states that:

- At all times, residents are able to shower, perform bodily functions and change clothing without non-medical staff of the opposite gender viewing their breasts, buttocks, or genitalia area. Except in emergency circumstances or when such viewing is incidental to routine room checks. If these situations were to occur, the viewing will be clearly documented in an incident report kept in the resident's file.
- Staff of the opposite gender must announce their presence when entering an area where residents are likely to be showering, performing bodily functions or changing clothing *(p. 1).*

Interviews

Random Sample of Staff: Only four the twelve interviewed random staff reported that all staff announce their presence when entering the housing unit does not matter the gender. All of the interviewed stated that residents can dress, shower and use the toilet without being viewed by staff or other residents. Several staff also reported that opposite gender staff are not allowed to monitor the shower area during shower time. The auditor discussed the lack of announcements with the management team to develop a process of making announcements.

Random Sample of Residents: Approximately five residents stated that staff consistently announce their presence when entering the housing area or any area where resident is showering, changing clothes, or performing bodily functions. The residents stated that opposite gender staff are not in the shower area during shower time. All of the 20 interviewed residents reported that they are able to dress, shower, and toilet without being seen naked and in full view of opposite gender staff. One resident stated that sometimes when he showers, he feels like staff can see him.

The auditor noted that the shower curtains also provided limited ability for staff to identify how many individuals were in the same shower at one time. The auditor requested that the facility adjust the shower curtains, so they are PREA compliant. During in the post audit phase, the facility made adjustments to the shower curtains and provided picture notification of proof.

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

115.315 (e.) As reported in the PAQ, the facility has a policy prohibiting staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining the resident's genital status. Policy & Procedures, *Searches, Contraband, Cross Gender Viewing*, states that, "transgender or intersex residents are never to be searched for the sole purpose of determining the resident's genital status" *(p. 1)*.

Interviews

Random Sample of Staff: Twelve interviewed random staff stated that they are aware that the facility policy that prohibits staff from searching or physically examining a transgender or intersex resident for the sole purpose of determining their genital status. Upon review of the PREA Training Curriculum, it is further confirmed that the facility does not train on cross-gender searches, or searches on transgender residents to determine genital status.

Documentation Reviewed

PREA Training Curriculum

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

115.315 (f). As reported in the PAQ, the Woodward Academy facility trained zero of security-staff on conducting cross-gender pat down searches and searches of transgender and intersex residents in a professional and respectful manner, consistent with security needs as such searches are prohibited. Policy & Procedures, *Searches, Contraband, Cross Gender Viewing*, states that "a resident may only be searched with significant cause and with the permission by upper-level management, this will only be a pat down search. Residents will only be searched in a private area with two members of the same sex employee. Cross-gender strip, visual body cavity, and pat-down searches are prohibited no exigent circumstances. Residents will never be asked to remove under garments" (p. 1).

Interviews

Random Sample of Staff: Twelve random staff representing all shifts working during the audit period were interviewed. Thirteen random staff representing all shifts working during the audit period were interviewed. Thirteen of the interviewed staff reported that they are not train nor do they conduct cross gender pat down searches.

Documentation Reviewed

Staff Training Records/New Hire– 52
PREA Training Curriculum

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

Corrective Action:
The auditor noted that the shower curtains also provided limited ability for staff to identify how many individuals were in the same shower at one time. The auditor requested that the facility adjust the shower curtains, so they are PREA compliant. During in the post audit phase, the facility made adjustments to the shower curtains and provided picture notification of proof.

No further corrective action is recommended for this standard.

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

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

115.316 (a)

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

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

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

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

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

- Does the agency take appropriate steps to ensure that residents with disabilities have an equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment, including: Other? (if "other," please explain in overall determination notes.) ☒ Yes ☐ No

- Do such steps include, when necessary, ensuring effective communication with residents who are deaf or hard of hearing? ☒ Yes ☐ No

- Do such steps include, when necessary, providing access to interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have intellectual disabilities? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Have limited reading skills? ☒ Yes ☐ No

- Does the agency ensure that written materials are provided in formats or through methods that ensure effective communication with residents with disabilities including residents who: Are blind or have low vision? ☒ Yes ☐ No

115.316 (b)

- Does the agency take reasonable steps to ensure meaningful access to all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment to residents who are limited English proficient? ☒ Yes ☐ No

- Do these steps include providing interpreters who can interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary? ☒ Yes ☐ No

115.316 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
   a. Pre-Audit Questionnaire (PAQ)
   b. Policy:
      i. PREA Zero Tolerance
      ii. HR Policy and Procedure Manual (tab 10)
   c. Posters:
      i. PREA
      ii. Zero Tolerance
      iii. HIPAA
      iv. Ombudsman Poster
      v. Interpreter Poster, The Right Care Right Now
   d. PREA Brochures (English/Spanish)
   e. Student Rights
   f. Staff Training Curriculum
   g. Staff Training records
   h. Updated PREA Training (139)

2. Interviews:
   a. Executive Director
   b. Random sample of staff – 12
   c. Residents (with disabilities or who are limited English proficient)

Findings (By Provision):

115.316 (a). As reported in the PAQ, the Woodward Academy facility, has established procedures to provide disabled residents equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Policy *PREA Zero Tolerance* states that "the facility will provide client education in formats accessible to all clients, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as the clients who have limited reading skills" *(p. 2)*.

Documentation Reviewed

- Interpreter Poster, The Right Care Right Now
- HIPAA Poster
- Ombudsman Poster (Spanish/English)
- PREA Poster
- Zero Tolerance Poster
- PREA Brochure (English/Spanish)
- Staff Training Curriculum
- Staff Training Records

Interviews

Agency Head: The interviewed agency head reported that the agency has a strict non-discrimination policy, which applies to all facets of treatment, including the prevention of sexual abuse. Facilities are required to provide clients with the information necessary for participation through a qualified interpreter or communication software, or through a written medium which is formatted in consideration of the client's communication needs (e.g., low vision, reading comprehension level, preferred language, etc.).

Residents (with disabilities or who are limited English proficient): Three residents who were identified as having a disability was interviewed. Two residents with cognitive disabilities and one resident with hearing limitations. All three of the residents stated that staff read the information to them, and they were able to understand the information. The residents also reported that if they needed help with reading, writing, speaking, and understanding information staff would help. One resident reported that they feel that staff minimizes their disability. The resident stated that staff do not believe he has diminished hearing and frequently minimized his hearing loss. The resident felt that staff should be more patient as he can hear some but often needs additional time understanding and comprehending everything. Such concerns were shared with the leadership team.

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

115.316 (b). As reported in the PAQ, the Woodward Academy facility has established procedures to provide residents with limited English proficiency equal opportunity to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment. Policy *PREA Zero Tolerance* states that "the facility will provide client education in formats accessible to all clients, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as the clients who have limited reading skills" *(p. 2)*.

The facility provided a poster, *The Right Care, Right Now* indicating that Conversant Audio Solutions would provide interpreter services.

Interviews

Residents (with disabilities or who are limited English proficient): Three residents who were identified as having a disability was interviewed. Two residents with cognitive disabilities and one resident with hearing limitations. All three of the residents stated that staff read the information to them, and they were able to understand the information. The residents also reported that if they needed help with reading, writing, speaking, and understanding information staff would help. One resident reported that they feel that staff minimizes their disability. The resident stated that staff do not believe he has diminished hearing and frequently minimized his hearing loss. The resident felt that staff should be more patient as he can hear

some but often needs additional time understanding and comprehending everything. Such concerns were shared with the leadership team.

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

115.316 (c). As reported in the PAQ, the Woodward Academy facility does not prohibit the use of resident interpreters, readers, or other types of resident assistance. Policy & Procedures, *W (p. 2)*."

Documentation Reviewed: The facility provided a poster, *The Right Care, Right Now* indicating that Conversant Audio Solutions would provide interpreter services.

Interviews

Random Sample of Staff: Twelve random staff interviewed reported they could not recall an incident that a resident interpreter was used to assist disabled residents or residents with limited English.

There were zero instances in the last 12 months where resident interpreters, readers, or other types of resident assistance was needed.

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

Corrective Action:
The following items are pending and will need to be provided in order to determine compliance:

- PREA brochures/education in another language. -completed
- Updated staff training curriculum and verification that staff received updated training. The facility provided verification that 139 staff received the updated training.

Standard 115.317: Hiring and promotion decisions
All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.317 (a)

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the hiring or promotion of anyone who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has engaged in sexual abuse in a prison, jail, lockup, community

confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. 1997)? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse? ☒ Yes ☐ No

- Does the agency prohibit the enlistment of services of any contractor who may have contact with residents who: Has been civilly or administratively adjudicated to have engaged in the activity described in the question immediately above? ☒ Yes ☐ No

115.317 (b)

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

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

115.317 (c)

- Before hiring new employees, who may have contact with residents, does the agency perform a criminal background records check? ☒ Yes ☐ No

- Before hiring new employees, who may have contact with residents, does the agency consult any child abuse registry maintained by the State or locality in which the employee would work? ☒ Yes ☐ No

- Before hiring new employees who may have contact with residents, does the agency, consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse? ☒ Yes ☐ No

115.317 (d)

- Does the agency perform a criminal background record check before enlisting the services of any contractor who may have contact with residents? ☒ Yes ☐ No

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

115.317 (e)

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

115.317 (f)

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in written applications or interviews for hiring or promotions? ☒ Yes ☐ No

- Does the agency ask all applicants and employees who may have contact with residents directly about previous misconduct described in paragraph (a) of this section in any interviews or written self-evaluations conducted as part of reviews of current employees? ☒ Yes ☐ No

- Does the agency impose upon employees a continuing affirmative duty to disclose any such misconduct? ☒ Yes ☐ No

115.317 (g)

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

115.317 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Policy:
        i. Prison Rape Elimination Act "PREA

ii. Employee Background Checks, Hiring and Promotions
b. Pre-audit Questionnaire (PAQ)
i. Employee File (20)
1. Interview Checklist
2. Woodward Academy Checklist
3. Single Contact License and Background Check
4. Verification of Reading Policy & Procedure Manual
5. Prevention of Sexual Assault/Rape Training Signature Page
c. Five-year background checks -- 9
d. Contract Background Checks – 5
2. Interviews:
a. HR administrator

Findings (By Provision):

115.317 (a). As reported in the PAQ, the Woodward Academy facility policy prohibits hiring or promoting anyone who may have contact with residents, and prohibits enlisting the services of any contractor who may have contact with residents, who:

1. Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution.
2. Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, of if the victim did not consent or was unable to consent or refuse; or
3. Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a) (2) of this section.

All of the above areas are asked in the Woodward Academy Checklist. In which the employee must acknowledge and sign. Policy & Procedures, *Employee Background Checks, Hiring and Promotions*, further reiterates the above requirements.

Documents Reviewed

Personnel Files of staff hired in the last 12 months (20)

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

115.317 (b). As reported in the PAQ, the Woodward Academy facility, has a policy that requires the consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with the residents. Policy & Procedures, *Employee Background Checks, Hiring and Promotions*, states that “the facility requires that a criminal background record check be completed, and applicable child abuse registries consulted before enlisting the services of any contractor who may have contact with residents” *(p. 2)*.

Interviews

Administrative (Human Resources) Staff: When interviewing the HR administrator, it was further reiterated that the Woodward Academy facility, has incorporated the above practices in its hiring of staff at the Woodward Academy facility. The facility takes all prior incidents into consideration for hiring and promotions.

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

115.317 (c). As reported in the PAQ, the agency policy requires the consideration of any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents. Policy Prison Rape Elimination Act "PREA" states that an employee record shall include "written, signed, and dated statement of disclosing any founded reports of child abuse, sex offender &/or dependent adult abuse completed by the Iowa Central Child Abuse Registry, which may exist on the new applicant' (*p.1*). The policy further states that new employees will receive a background check conducted by the Iowa Division of Criminal Investigations.

The facility stated in the PAQ that the number of staff hired in the last 12 months is 215.

Documents Reviewed
Personnel Files of staff hired in the last 12 months (20)

Interviews

Administrative (Human Resources) Staff: An interview with the human resources administrator, indicated that when conducting criminal record background checks consideration is made pertinent to civil or administrative adjudications for all newly hired employees who may have contact with residents and all employees, who may have contact with residents, who are considered for promotions. Criminal background checks and child abuse registry checks are conducted on all employees and they facility will start conducting background checks on contractors going forward.

The final analysis of the evidence indicates the facility requires that before hiring new employees who may have contact with residents, the agency shall: (1) Perform a criminal background records check; (2) Consults any child abuse registry maintained by the State or locality in which the employee would work; and (3) Consistent with Federal, State, and local law, make its best efforts to contact all prior institutional employers for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse. The policy provided in the PAQ aligns with the intent of the standard, as well as corroboration by the interviewee. The facility meets this portion of the provision.

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

115.317 (d). As reported in the PAQ, the agency policy requires that a criminal background record check will be completed before enlisting the services of any contractor who may have contact with residents. In the past 12 months, there were zero contracts for services where criminal background record checks were contacted on all staff covered in the contract who might have contact with residents. There were 12 contracts for services where criminal background record checks were conducted on all staff covered in the contract who might have contact residents. Policy & Procedures, *Employee Background Checks, Hiring and Promotions*, further states that "the facility requires that a criminal background record check be completed, and applicable child abuse registries consulted before enlisting the services of any contractor who may have contact with residents" *(p. 2)*. It further states that:

> Background check results will be stored in the employee's personnel file. These checks include Below list all facility background check requirements:

1. Criminal History unit background check
2. Sex Offender Registry
3. National Sex Offender Registry
4. State Driver's License Look Up
5. National Motor Vehicle Check Look Up
6. Board of Occupational Licenses
7. Office of Inspector General
8. Data Facts (*p.2*)

The contractors, volunteers, and interns are also required to review and sign a Woodward Academy Checklist document addressing any prior sexual abuse in a residential setting.

Interviews

Administrative (Human Resources) Staff: As previously indicated, the interviewed administrative staff reported that the facility performs criminal record background checks and considers pertinent civil or administrative adjudications for all newly hired employees who may have contact with residents and all employees, and all employees who are being considered for promotions. It was also reported that they will begin doing a background check on contractors going forward.

Documentation Reviewed

Contractor Background Checks -5

As previously indicated, the facility was not conducting background checks on all contractors. A corrective Action Plan was put in place to address the deficiency. The auditor reviewed five background checks that were conducted on contractors during the post onsite audit phase.

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

The Woodward Academy facility, Policy & Procedures, *Employee Background Checks, Hiring and Promotions*, "requires that criminal background record checks be conducted at least every five years of current employees and contractors who may have contact with residents or that a system is in place for otherwise capturing such information for current employees" *(p. 2)*.

Documentation Reviewed

5-year background checks-9

Interviews

Administrative (Human Resources) Staff: The interviewed HR staff reported that Woodward Academy uses the State of Iowa criminal background checks upon hire and every year thereafter for employees and will start doing background checks with contractors going forward.

Corrective Action

Since five-year background checks were not readily made available during the pre and onsite audit phase, the facility entered into a corrective action to provide proof of documentation. During the post

onsite audit phase documentation was provided showing the background checks being conducted. The corrective action has been addressed.

115. 317 (f). The Woodward Academy facility has all newly hired and promoted employees complete a Pre-Employee Questionnaire form. Policy & Procedures, *Employee Background Checks, Hiring and Promotions*, (*p. 2*), states that, "applicants must complete an application statement and driving record form authorizing the facility to perform background checks".

Interviews

Administrative (Human Resources) Staff: When interviewing the human resources staff during the on-site audit, it was reported that the background checks are conducted on employees, and they will implement are process for contractors in accordance with the PREA standards. The interviewed staff could not confirm that all applicants and employees who have contact with residents are asked about previous misconduct in written applications for hiring or promotions; and there is a continued affirmative duty to disclose any such previous misconduct.

115.317 (g). According the to the PAQ, the agency's policy states that material omission regarding misconduct, or the provision of materially false information, shall be grounds for termination. The agency's Policy & Procedures, *Employee Background Checks, Hiring and Promotions*, further reiterates "material omissions regarding such misconduct, or the provision of materially false information, shall be grounds for termination" *(p. 2)*.

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

115.317 (h). The agency's Policy & Procedures, *Employee Background Checks, Hiring and Promotions*, states that "Unless prohibited by law, the agency shall provide information on substantiated allegations of sexual abuse or harassment involving a former employee upon receiving a request from an institutional employer for whom such employee has applied to work" *(p. 3)*.

Interviews

Administrative (Human Resources) Staff: The interviewed HR administrator confirmed that the facility will provide information on employment and can provide detailed information on a former employee (s), substantiated allegation of sexual abuse or sexual harassment, upon receiving a request from an institutional employer.

Corrective Action:
The following items are pending and will need to be provided in order to determine compliance:

- Sample of 5 year or annual background check
- Background checks for contracted staff

The corrective action was addressed during the post onsite audit phase. There are no further actions needed, the facility is in compliance with the standard.

Standard 115.318: Upgrades to facilities and technologies

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

115.318 (a)

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

115.318 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
   a. Pre-Audit Questionnaire (PAQ)
   b. Ariel View and Map
2. Interviews:
   a. Agency head
   b. Executive Director

Findings (By Provision):
115.318 (a). The facility indicated in their responses to the Pre-Audit Questionnaire (PAQ) that the facility has acquired a new facility or made substantial expansions or modifications to the existing facility since

Documentation Reviewed

Ariel View and Map

Interviews

Agency Head: The interviewed agency head reported that during the acquisition and planning process, the agency requires that facility leadership considers the structure and staffing model of the facility, and whether barriers exist that negatively impact staff from adequately supervising, surveilling, or caring for clients to prevent, detect, and respond to sexual abuse. If such barriers exist, the agency requires that facility leadership corrective action plan accordingly.

Executive Director (ED): The interviewed ED reported that infinity hall was created. Video surveillance was installed, and all policy and procedures of best practices were implemented as the other dorms had. The facility also expanded the dorms at an appropriate rate of speed to go in line with appropriate staffing levels as well as appropriate normative behavior management.

A review of the appropriate documentation and review of relevant polices indicate that the facility is compliant and exceeds the requirements of the provision of this standard. No corrective action is warranted.

115.318 (b). The facility reported in the PAQ that they have installed or updated its video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012, or since the last PREA audit. A memo was provided indicating the facility has not had any updates or changes to its video monitoring system.

Interviews

Agency Head: The interviewed agency head stated that routine monitoring of milieu management, by facility leadership, through the use of monitoring technologies enhances leadership's ability to detect circumstances that may increase the risk of client sexual abuse and corrective action plan accordingly. Technology also assists with leadership's supervision of corrective actions.

Agency leadership has granted facility leadership the autonomy to determine whether or not new technology is needed to assist with supervision, surveillance, or investigation of client sexual abuse. For example, the use of security cameras, alarm systems, or nighttime visual supervision technology may be in place at facilities as needed.

Executive Director (ED): The ED reported that Woodward Academy took advice from other schools on the number of cameras to utilize as appropriate placement of cameras to cover the most space. The facility also uses electronic monitoring on all outer doors on all dorms. On the problematic sexualized behavior dorms, there is electronic monitoring in rooms to keep students in their own beds.

A review of the appropriate documentation and review of relevant polices indicate that the facility is compliant with the provisions of this standard. No corrective action is warranted.

Corrective Action:
No corrective action is recommended for this standard.

RESPONSIVE PLANNING

Standard 115.321: Evidence protocol and forensic medical examinations

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

115.321 (a)

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

115.321 (b)

- Is this protocol developmentally appropriate for youth where applicable? (N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations.) ☒ Yes ☐ No ☐ NA

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

115.321 (c)

- Does the agency offer all residents who experience sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate? ☒ Yes ☐ No

- Are such examinations performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible? ☒ Yes ☐ No

- If SAFEs or SANEs cannot be made available, is the examination performed by other qualified medical practitioners (they must have been specifically trained to conduct sexual assault forensic exams)? ☒ Yes ☐ No

- Has the agency documented its efforts to provide SAFEs or SANEs? ☒ Yes ☐ No

115.321 (d)

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

- If a rape crisis center is not available to provide victim advocate services, does the agency make available to provide these services a qualified staff member from a community-based

organization, or a qualified agency staff member? (N/A if the agency *always* makes a victim advocate from a rape crisis center available to victims.) ☐ Yes ☐ No ☒ NA

- Has the agency documented its efforts to secure services from rape crisis centers? ☒ Yes ☐ No

115.321 (e)

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

- As requested by the victim, does this person provide emotional support, crisis intervention, information, and referrals? ☒ Yes ☐ No

115.321 (f)

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

115.321 (g)

- Auditor is not required to audit this provision.

115.321 (h)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        i. Medical Services
        ii. PREA Zero Tolerance
    c. Specialized Training: Medical and Mental Healthcare
    d. Specialized Training for PREA Investigator (2)
    e. Blank Children's Center
2. Interviews:
    a. Random sample of staff - 12
    b. PREA compliance manager
    c. Reported sexual abuse - 4

Findings (By Provision):

115.321 (a). The facility indicated in their responses to the Pre-Audit Questionnaire that the agency/facility is responsible for conducting administrative sexual abuse investigations. Outside law enforcement will conduct the criminal investigations. The agencies responsible for criminal investigations is Woodward Policy Department. The PREA Zero Tolerance policy states that "each incident of alleged or reported sexual abuse or sexual assault/rape must be investigated to the fullest extent possible. Evidence collected must be maintained under strict control. Based on the results of the investigation, the Executive Director and Prosecuting Authorities will meet if prosecution is appropriate" (p. 6).

After further review it was determined that the facility conducts some of the administrative portion of the investigative process; therefore, the auditor recommended that they have a designated staff member responsible for conducting administrative investigations and completing the specialized training. Two staff completed the specialized training.

Documentation Reviewed

NIC Specialized Training Certificate

Interviews

Random Sample of Staff: During the on-site audit, 12 random staff were interviewed regarding if they understood the agency's protocol for obtaining usable physical evidence if a resident alleges sexual abuse. All of the interviewed staff reported that they were knowledgeable of the agency's protocols and able to explain the process they would take to protect any evidence. Staff explained they would immediately move resident to a safe location, secure the area, contact supervisor for next steps. Twelve staff were asked if they know who is responsible for conducting sexual abuse investigations after a report of sexual abuse or sexual harassment has been made six staff stated the supervisor, higher command, law enforcement or the "PREA person" would conduct the investigation.

Corrective Action

Designated staff completing the Specialized Training for Investigation Staff. Corrective action was addressed, and the facility is in compliance with the provision.

A review of the appropriate documentation and review of relevant polices indicate that the facility is compliant with the provisions of this standard. No corrective action is warranted.

115.321(b). The facility indicated in their responses to the Pre-Audit Questionnaire that the protocol is developmentally appropriate for youth based on the most recent edition of the DOJ's Office on Violence Against Women publication, *"A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents"*, or similarly comprehensive and authoritative protocols developed after 2011.

A review of the appropriate documentation and review of relevant polices indicate that the facility is compliant with the provisions of this standard. No corrective action is warranted.

115.321 (c). The facility indicated in their responses to the Pre-Audit Questionnaire that the facility offers all residents who experience sexual abuse access to forensic medical examinations at an outside facility and that there is no charge for these examinations. The facility responded that residents are that forensic medical examinations are offered without financial cost to the victim. The facility reported that it does not document efforts to provide SAFE or SANEs. The facility also indicated that in the past 12 months there were zero forensic medical exams conducted, no exams performed by SANE/SAFEs, nor any exams were performed by a qualified medical practitioner.

The Woodward Academy facility does not have a formalized contract for SANE services. It was reported that services are offered by Blank Children's Center. Services offered "the Blank Children's STAR Center provides a variety of services including forensic interviews and forensic medical examinations. Specially trained interviewers talk to children when there is an allegation of abuse or neglect. The multidisciplinary team works in collaboration with law enforcement and the Department of Human Services. Forensic exams are conducted by a pediatrician and a nurse practitioner and can sometimes be used in evidence collection".

A review of the appropriate documentation and review of relevant polices indicate that the facility is compliant with the provisions of this standard. No corrective action is warranted.

115.321 (d). The facility indicated in their responses to the Pre-Audit Questionnaire that Woodward Academy attempts to make available to the victim, a victim advocate from a rape crisis center. If a rape crisis center is not available to provide victim advocate services, the facility does not make available to provide these services a qualified staff member from a community-based organization, or a qualified facility staff member.

The Woodward Academy facility does not have a formalized contract for SANE services. It was reported that services are offered by Blank Children's Center. Services offered "the Blank Children's STAR Center provides a variety of services including forensic interviews and forensic medical examinations. Specially trained interviewers talk to children when there is an allegation of abuse or neglect. The multidisciplinary team works in collaboration with law enforcement and the Department of Human Services. Forensic exams are conducted by a pediatrician and a nurse practitioner and can sometimes be used in evidence collection".

<u>Documentation Reviewed</u>

Blank's Children's Center Information

Interviews

PREA Compliance Manager: The interviewed PREA compliance manager reported that the agency can access a victim advocate by calling the rape crisis center. The facility will follow PREA guidelines to make sure they meet qualifications.

Residents who Reported a Sexual Abuse: Four residents interviewed during the audit, reported sexual abuse while at the facility. All of the residents reported that they were able to contact family. One resident stated that they didn't get to talk to his mom for two days and one resident stated that while he was offered, he didn't want to involve his family.

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

115.321 (e). The facility indicated in their responses to the Pre-Audit Questionnaire that they would provide, if requested by the victim, a victim advocate, a qualified agency staff member, or a qualified community-based organization staff member to accompany and support the victim through the forensic medical examination process and investigatory interviews and to provide emotional support, crisis intervention, information, and referrals. As previously stated, the facility will utilize community-based advocacy services at the Blank's Children's Center.

Documentation Reviewed

Blank's Children's Center Information

Interviews

PREA Compliance Manager: Interviews with the PREA compliance manager reported that they will utilize an outside rape crisis center.

Residents who Reported a Sexual Abuse: Three of the four interviewed residents stated that they were allowed to contact their parents/guardians immediately after they reported sexual abuse. One resident stated that they did not talk to their parent/guardian for two days after the allegation was made. All of the residents reported that they can have ongoing communication with their resident/guardian.

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

115.321 (f). As indicated in the PAQ the Woodward Academy facility is only responsible for conducting administrative investigations. Criminal investigations are conducted by the local police department.

As previously stated, the facility does not conduct investigations, however after further review it was determined that the facility conducts some of the administrative portion of the investigative process; therefore, the auditor recommended that they have a designated staff member responsible for conducting administrative investigations and completing the specialized training. Two staff completed the specialized training.

There is no further action required for the provision.

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

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

Corrective Action:
The following items are pending and will need to be provided in order to determine compliance:

- Certificate for internal investigator staff that they completed the NIC Specialized Training for Investigators.

The corrective action was addressed during the post audit phase, there is no further action required. The facility is in compliance with the standard.

Standard 115.322: Policies to ensure referrals of allegations for investigations

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

115.322 (a)

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

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

115.322 (b)

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

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

- Does the agency document all such referrals? ☒ Yes ☐ No

115.322 (c)

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

115.322 (d)

- Auditor is not required to audit this provision.

115.322 (e)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        i. Prison Rape Elimination Act "PREA"
    c. NIC Specialized Training for PREA Investigator Certificate -2
    d. Investigations (12)
        i. Internal Investigation Report
        ii. Summary of interview
        iii. Incident Review
        iv. Notification
2. Interviews:
    a. Agency head
    b. Investigative Staff - 2

Findings (By Provision):

115.322 (a). The Woodward Academy facility reported in the PAQ that the facility ensures that administrative and criminal investigations are completed for all allegations of sexual abuse and sexual harassment. In the past 12 months there were 10 allegations of sexual abuse and sexual harassment. Those same 10 allegations were administratively investigated and four were referred for criminal investigation. There were two additional allegations identified by the onset audit date: therefore, a total of 12 allegations of sexual abuse or sexual harassment.

Policy *Prison Rape Elimination Act "PREA"* states that "each incident of alleged or reported sexual abuse or sexual assault/rape must be investigated to the fullest extent possible" *(p.9*). While the facility reported that they do not conduct administrative or criminal investigations, after further review it was determined that the facility conducts some of the administrative portion of the investigative process; therefore, the auditor recommended that they have a designated staff member responsible for conducting administrative investigations and completing the specialized training. Two staff completed the specialized training.

Documentation Reviewed

Twelve investigation files of allegations of sexual abuse and/or sexual harassment were reviewed. The documentation verified a process of investigating allegations of sexual abuse and/or sexual harassment.

Specialized Training for Investigators Certificate -2

Interviews

Agency Head: The interviewed agency head reported that it is the agency's policy that all allegations of abuse, regardless of perpetrator, are reported to external investigative authorities (i.e., CPS, APS, law enforcement) for investigation as well as reported internally to agency leadership. It is the agency's policy that, subsequent to the reporting and determination of investigatory requirements by external investigators, an internal administrative and/or external investigation is completed for all allegations of abuse and the outcome is reported to agency leadership. As the agency does not have a website, this mandatory reporting policy is trained to all staff. Allegations of abuse, and referrals for investigation, are reported to the agency via an internal risk management reporting system.

It was also reported that it is the agency's policy that allegations are reported to external authorities for investigation, in compliance with federal, state, and local laws. If an external agency chooses to pursue a criminal investigation, it is the agency's policy to fully cooperate with investigations. Facilities are not to interfere with external investigations and are to respect the findings of the investigation and any subsequent administrative actions or options. If an external agency does not substantiate an allegation, the facility may still conduct an administrative investigation to determine if a violation of company policy has occurred and require remedial action. Only qualified investigators may lead such investigations and finalize findings and recommendations. The agency reserves the right to take corrective or disciplinary action that is stricter than that recommended by the facility investigator.

115.322 (b). As reported in the PAQ, the Woodward Academy facility has a policy that requires allegations of sexual abuse or sexual harassment be referred for investigation to an agency with the legal authority to conduct criminal investigations. Policy *Prison Rape Elimination Act "PREA"*, states that, "Qualified investigators must take victim statements, open an investigation, and if applicable collect physical evidence" (*p. 10*).

The facility conducts administrative investigations. Local law enforcement and CPS also investigate allegations of sexual abuse and sexual harassment.

Documentation Reviewed
Specialized Training for Investigators Certificate -2

Interviews
Investigative Staff: The facility has two investigative staff. Both staff were interviewed. The interviewed investigators reported that they will follow agency policy which states that if a student reports sexual abuse, we interview, gather facts, and report to law enforcement/child protective services (CPS).

115.322 (c). As reported, Woodward Academy is not responsible for conducting the administrative investigations. All allegations are handled by an outside law enforcement entity. After further review, it was determined that the facility may conduct a portion of the administrative investigation therefor two staff completed specialized training during the post onsite audit phase.

Documentation Reviewed

Specialized Training for Investigators Certificate -2

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

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

Corrective Action:
The following items are pending and will need to be provided in order to determine compliance:

- Certificate for internal investigator staff that they completed the NIC Specialized Training for Investigators.

The corrective action was addressed during the post audit phase. There is no further action needed. The facility is in compliance with the standard.

TRAINING AND EDUCATION

Standard 115.331: Employee training
All Yes/No Questions Must Be Answered by the Auditor to Complete the Report

115.331 (a)

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

- Does the agency train all employees who may have contact with residents on how to communicate effectively and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents? ☒ Yes ☐ No

- Does the agency train all employees who may have contact with residents on how to comply with relevant laws related to mandatory reporting of sexual abuse to outside authorities? ☒ Yes ☐ No

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

115.331 (b)

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

115.331 (c)

- Have all current employees who may have contact with residents received such training? ☒ Yes ☐ No

- Does the agency provide each employee with refresher training every two years to ensure that all employees know the agency's current sexual abuse and sexual harassment policies and procedures? ☒ Yes ☐ No

- In years in which an employee does not receive refresher training, does the agency provide refresher information on current sexual abuse and sexual harassment policies? ☒ Yes ☐ No

115.331 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        i. *Prison Rape Elimination Act "PREA"*
        ii. *PREA Zero Tolerance Policy*
    c. Prevention of Sexual Assault/Rape Training Signature Page
    d. *PREA Training*
    e. *PREA Training Log -20*
    f. Base Training Schedule
    g. Updated PREA Training Curriculum
    h. Completed updated training (139)
2. Interviews:
    a. Random sample of staff - 12

Findings (By Provision):

115.331 (a). As reported in the PAQ, the agency trains all employees who may have contact with residents on the following matters:

- Agency's zero-tolerance policy for sexual abuse and sexual harassment.
- How to fulfill their responsibility under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures.
- The right of residents to be free from sexual abuse and sexual harassment.
- The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment.
- The dynamics of sexual abuse a sexual harassment in confinement.
- The common reactions of sexual abuse and sexual harassment victims.
- How to detect and respond to signs of threatened and actual sexual abuse.
- How to avoid inappropriate relationships with residents.
- How to communicate effective and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender-nonconforming residents; and
- How to comply with relevant laws related to mandatory reporting of sexual abuse t outside authorities.

Policy *Prison Rape Elimination Act "PREA"* states that "all Woodward Academy staff, contractors, and volunteers that have regular contact with students, must complete initial and annual training for sexual assault/rape prevention, incident response and reporting" (*p. 5*).

<u>Documentation Reviewed</u>

Staff Development and Training curriculums were evaluated by the auditor, and it was identified that the training did not contain all of the required elements. Trainings shall be documented through employee

signature and maintained on *the Verification of Sexual Assault/Rape Training Signature Page* form. The auditor reviewed 20 records of staff completion of training in the last 12 months.
Updated PREA Training Curriculum

Interviews

Random Staff: Twelve staff, representing staff from all shifts, were interviewed. Interviews confirmed that each of the staff received PREA education during the initial job training. Interviews with staff indicated they are all were aware of the Zero Tolerance Policy, employee and resident rights, signs and symptoms of sexual abuse, reporting and responding. The direct care staff reported being knowledgeable of the topics they had been trained in. The staff were able to describe the training on zero tolerance, Residents and staff rights, dynamics of sexual abuse and sexual harassment, prevention and response protocol as well supportive services available to residents. Five of the staff could not recall if they received training on effectively communicating with lesbian, gay, bisexual, transgender, intersex, or gender non-conforming residents.

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

115.331 (b). The facility reported in the PAQ that training is tailored to meet the unique needs and attributes and gender of the residents at the Woodward Academy facility. Policy PREA Zero Tolerance, states that When staff that have been trained later transfer to work in a unit housing of a different gender, then additional gender-specific training is required" (*p. 3*).

Documentation Reviewed

Training Curriculum

Updated Training Curriculum

Completed Updated Training (1390)

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

115.331 (c). As reported in the PAQ, the agency trains all employees who may have contact with residents on the following matters: zero of the Woodward Academy staff currently employed were trained or retrained on the PREA requirements. It was also reported in the PAQ that 215 staff received at hire annual and/or refresher training; and approximately 400-600 have been trained since the last PREA audit.

Policy & Procedures, *Zero Tolerance*, states that "All facility staff, contractors and volunteers that have regular contact with residents, must complete initial and annual training for sexual assault/rape prevention, incident response and reporting. At the conclusion of each training session, all trainees must sign that they attended and understood the training. This signature sheet must be kept on file for all initial and annual trainings" (*pp. 4-5*).

Documentation Reviewed

PREA Training Curriculum

Updated PREA Training Curriculum

Training Log-20

Completed Updated training (139)

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

115.331 (d). As reported in the PAQ, the agency documents that employee who may have contact with residents understand the training they have received through employee signature or electronic verification. Policy *Prison Rape Elimination Act "PREA"* states that "at the conclusion of each training session, all trainees must sign that they attended and understood the training. This signature sheet must be kept on file for a period determined by Woodward's "Record Retention Schedule"" (*p. 5*).

Trainings shall be documented through employee signature and maintained on *the Verification of Sexual Assault/Rape Training Signature Page* form. The auditor reviewed 20 records of staff completion of training in the last 12 months.

During the pre, on-site, and post-site phase, documentation review of 20 employees indicated acknowledgement of training received. The training records reviewed, provided evidence that the facility consistently conducts annual training with staff, and there was adequate documentation of employee signatures verifying the employee's comprehension of the training.

Documentation Reviewed
PREA Training Curriculum

Updated PREA Training Curriculum

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

Corrective Action:
The following items are pending and will need to be provided in order to determine compliance:
The current PREA Training does not contain all of the required elements. Need to update the training and conduct a refresher with all staff. Provide proof of the updated training along with the refresher.
Required elements:

- Agency's zero-tolerance policy for sexual abuse and sexual harassment.
- How to fulfill their responsibility under agency sexual abuse and sexual harassment prevention, detection, reporting, and response policies and procedures.
- The right of residents to be free from sexual abuse and sexual harassment.
- The right of residents and employees to be free from retaliation for reporting sexual abuse and sexual harassment.
- The dynamics of sexual abuse a sexual harassment in confinement.
- The common reactions of sexual abuse and sexual harassment victims.
- How to detect and respond to signs of threatened and actual sexual abuse.
- How to avoid inappropriate relationships with residents.

- How to communicate effective and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender-nonconforming residents; and
- How to comply with relevant laws related to mandatory reporting of sexual abuse t outside authorities.
    - 115.331 (b). Do you have any gender specific training?
    - 115.331 (c). Need verification that existing staff completed PREA refresher training prior to the onsite audit date.

The curriculum was updated during the post audit phase. During the post audit phase, the facility provided documentation that 139 staff received the updated PREA training. The standard has been corrected and there is no further action. The standard is in compliance.

Standard 115.332: Volunteer and contractor training

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

115.332 (a)

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

115.332 (b)

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

115.332 (c)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        i. Prison Rape Elimination Act "PREA"
    c. PREA Training for Contractors
    d. Training Log-5
    e. Specialized Training or Medical/Mental Health Staff-9
2. Interviews:
    a. Contractor -1

Findings (By Provision):

115.332 (a). According to the PAQ, all volunteers and contractors who have contact with resident have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse/harassment prevention, detection, and response. It was further reported that zero volunteers or contractors have been trained in the past 12 months on the agencies zero tolerance policy for sexual abuse and sexual harassment.

Policy *Prison Rape Elimination Act "PREA"* states that "all Woodward Academy staff, contractors, and volunteers that have regular contact with students, must complete initial and annual training for sexual assault/rape prevention, incident response and reporting" (*p. 5*). The facility has contracted medical services. The medical staff have completed the online specialized training for medical and mental health. The auditor reviewed the training certificates of three medical staff. In addition, the staff reviewed five contracted staff completion of the PREA training. Due to COVID-19 there were no volunteers authorized to participate facility. The facility provided a memo of explanation for the volunteers.

<u>Documentation Reviewed</u>
Contractor Training Log
Contractor Curriculum

<u>Interviews</u>

Contractors who have contact with residents: The interviewed contracted staff reported that they have received training related to sexual abuse and sexual harassment. The training was conducted online. The individual further reported that they have full access to the policies related to the Prison Rape Elimination Act.

115.332 (b). As reported in the PAQ, the level and type of training provided to volunteers and contractors is not based on the services they provide and level of contact they have with residents; however, all volunteers and contractors have been notified of the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and informed how to report such incidents.

<u>Documentation Reviewed</u>
Contractor Training Log
Contractor Curriculum

Interviews

Contractors who have contact with residents: The interviewed contracted staff reported that they have received training related to sexual abuse and sexual harassment. The training was conducted online. The individual further reported that they have full access to the policies related to the Prison Rape Elimination Act.

115.332 (c). As reported in the PAQ, the Woodward Academy facility maintains documentation confirming that volunteers/contractors understand the training they have received. Policy *Prison Rape Elimination Act "PREA"* states that "at the conclusion of each training session, all trainees must sign that they attended and understood the training. This signature sheet must be kept on file for a period determined by Woodward's "Record Retention Schedule" (*p. 5*).

There were no volunteers during the 12-month audit period. As previously stated, that facility has contracted medical staff, and proof of training is documented.

Documentation Reviewed
Contractor Training Log
Contractor Curriculum

Corrective Action:
The following items are pending and will need to be provided in order to determine compliance:

- Need verification that contracted staff and volunteers received PREA Training? Provide a copy of the training curriculum for volunteers and contractors.

The corrective action was addressed during the post audit phase. There are no additional requirements. The standard has been corrected and there is no further action. The standard is in compliance.

Standard 115.333: Resident education

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

115.333 (a)

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

115.333 (b)

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

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

- Within 10 days of intake, does the agency provide age-appropriate comprehensive education to residents either in person or through video regarding: Agency policies and procedures for responding to such incidents? ☒ Yes ☐ No

115.333 (c)

- Have all residents received the comprehensive education referenced in 115.333(b)? ☒ Yes ☐ No

- Do residents receive education upon transfer to a different facility to the extent that the policies and procedures of the resident's new facility differ from those of the previous facility? ☒ Yes ☐ No

115.333 (d)

- Does the agency provide resident education in formats accessible to all residents including those who: Are limited English proficient? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are deaf? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are visually impaired? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Are otherwise disabled? ☒ Yes ☐ No

- Does the agency provide resident education in formats accessible to all residents including those who: Have limited reading skills? ☒ Yes ☐ No

115.333 (e)

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

115.333 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        i. Equal Employment Opportunity (tab 10)
        ii. Personnel Policies (tab 10)
        iii. Grievance Procedure
        iv. Medical Services
        v. Prison Rape Elimination Act "PREA"
        vi. PREA Zero Tolerance
    c. PREA Brochure (English, Spanish)
    d. Resident Admissions Packet: (20)
        i. Admissions Checklist
        ii. Student Profile Information Form
        iii. Woodward Academy Grievance Procedure
        iv. Student Advisement
        v. Magellan Health Services
        vi. Student Internet Acceptable Use and Safety Policy
        vii. Personal Rights
        viii. Student Orientation Packet
        ix. Student Signature sheet for PREA Orientation
2. Interviews:
    a. Intake staff - 1
    b. Random sample of residents - 20
3. On-site observation
    a. PREA Posters

Findings (By Provision):
115.333 (a). Per the PAQ, 219 residents were admitted during the past 12 months received information at the time of intake of the zero-tolerance policy and how to report incidents or suspicions of sexual abuse or harassment. The *Prison Rape Elimination Act "PREA"* policy states that a new student orientation process will take place upon admission or the first business day after admission (*p. 3*). In addition, the policy states that "within 10 days of intake, Woodward Academy 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" (*p. 3*).

Documentation Reviewed
Residence Admission Packet (20)
PREA Brochure English/Spanish
PREA Video show to new residents

During the intake process residents receive PREA related education in an age-appropriate fashion. The residents receive an educational pamphlet and watch a PREA video.

Interviews

Intake Staff: One interviewed intake staff reported that during the intake process residents are given provided PREA related information in the admission packet paperwork. The paperwork is discussed with the youth and the nurses review it as well in the initial assessment.

Random Sample of Residents: Twenty residents were interviewed. All of the interviewed residents were able to clearly articulate they understood their rights are not sexually abused or sexually harassed while at the facility. Four of the 20 interviewed residents could not recall if and when they were given information related to sexual abuse and/or sexual harassment. When probed the residents who could recall reported that they received the information on the same day, within a couple of days and/or the first week. The residents also reported that the information was provided to them, and they received an orientation book that contained information on the facilities zero tolerance policy on sexual abuse and/or sexual harassment.

There were no residents interviewed that spoke another primary language or had visual, hearing, other physical or learning disabilities that caused conflict with comprehending questions during interview.

The facility has two ways in which they educate residents, and in order to show compliance with the standard the facility shall provide proof that the residents also received PREA education when they signed the Student Orientation packets/Student Orientation Sheet for PREA Information. Upon review of 20 PREA education statements the facility is in compliance with the standard. In addition, it should be noted that the residents received said information within 24 hours of placement at the facility.

115.333 (b). As reported in the PAQ, 219 residents that were admitted in the facility during the past 12 months, who's length of stay was for 10 days or more received comprehensive education regarding their right to be free from both sexual abuse/harassment and retaliation for reporting such incidents and on agency policies and procedures for responding to such incidents.

Documentation Reviewed
Intake Records (Resident admission packets). Upon review of 20 resident admission packets, it was observed that the residents received comprehensive age appropriate PREA education within 10 days of intake. The facility exceeded the requirements in that residents received PREA education within 24 hours of placement at the facility.

Interviews
Intake Staff: One interviewed intake staff reported that the admission packet which includes PREA related information is discussed at admissions and the nurses review PREA during the initial assessment. The process occurs on the day of intake.

Random Sample of Residents: Twelve residents were interviewed. All of the interviewed residents were able to clearly articulate they understood their rights are not sexually abused or sexually harassed while at the facility. Four of the 12 interviewed residents could not recall if and when they were given information related to sexual abuse and/or sexual harassment. When probed the residents who could recall reported that they received the information on the same day, within a couple of days and/or the first week. The residents also reported that the information was provided to them, and they received an orientation book that contained information on the facilities zero tolerance policy on sexual abuse and/or sexual harassment.

The auditor reviewed intake records of residents entering the facility in the past 12 months and resident interviewed for verification. This information is documented. The auditor also reviewed relevant educational materials including the PREA video, posters, resident handbooks, pamphlets, and *PREA Student Orientation Packet.*

115.333 (c). As reported in the PAQ, all 219 residents received PREA related education within 10 days of being placed at the facility. The *Prison Rape Elimination Act "PREA"* policy states that a new student orientation process will take place upon admission or the first business day after admission (*p. 3*). During orientation the resident will receive information on the zero-tolerance policy. In addition, the policy states that "within 10 days of intake, Woodward Academy 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" (*p. 3*).

The facility also reported that residents transferred from another facility would not receive PREA education upon intake and during orientation. Upon review of intake records, all youth whether or not they were transferred from a facility received PREA education upon intake and during orientation.

Documentation Reviewed

Intake Records (Resident admission packets). Upon review of 20 resident admission packets, it was observed that the residents received comprehensive age appropriate PREA education within 10 days of intake. The facility exceeded the requirements in that residents received PREA education within 24 hours of placement at the facility. All residents housed at the facility have been placed at the facility since 2012.

Interviews

Intake Staff: As previously stated the PREA related paperwork is discussed at intake and the nurse reviews it as well during their initial assessment.

Documentation provided to the auditor during the post-audit visit indicated that the information is given in an age-appropriate fashion. Upon review of the *Signature Sheet for PREA Orientation*, it appears that the residents received education on the same day of arrival. Overall, the facility exceeded the time frames and requirements to provide PREA education and material to residents.

115.333 (d). As indicated in the PAQ, resident PREA education is available in formats accessible to all residents, including those that are: limited English proficient (LEP), deaf, visually impaired, otherwise disabled, limited in their reading skills. The *PREA Zero Tolerance Policy* states that "the information provided to clients during orientation must be provided verbally and in written form in 2 separate occasions within a 10-day time frame. Further, the information must be in a language and format that the client can understand" (*p.* 2).

Documentation Reviewed

PREA Brochure English/Spanish

A review of the appropriate documentation, interviews with appropriate staff and review of relevant policies indicate that the facilities in compliance with the provisions of this standard. No corrective action is warranted. There were no residents who met the criteria of this provision to be interviewed at the time of the audit.

115.333 (e). As reported in the PAQ, the agency maintains documentation of resident participation in the PREA education sessions. Documentation of resident's participation in the PREA comprehensive education sessions is available per policy and facility procedures in the resident files. Resident intake records were reviewed to assure fidelity with this documentation. The auditor reviewed youth acknowledgement forms of 20 residents entering the facility in the past 12 months.

Documentation Reviewed
Intake Records (Resident admission packets). Upon review of 20 resident admission packets, it was observed that the residents received comprehensive age appropriate PREA education within 10 days of intake.

115.333 (f). The facility reported in the PAQ that the agency will ensure that key information is continuously and readily available or visible to residents through posters, resident handbooks, or other written formats. Based on site review, the PREA materials (including posters, PREA education, resident handbooks, and brochures) were available. The residents housed at the facility had ready access to PREA related material. The auditor recommended displaying information in English and Spanish.

Documentation Reviewed
Intake Records (Resident admission packets). Upon review of 20 resident admission packets, it was observed that the residents received comprehensive age appropriate PREA education within 10 days of intake.

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

Corrective Action:
The following items are pending and will need to be provided in order to determine compliance:

- Upload the resident PREA video to the shared site
- Need PREA Brochures in Spanish/English

The above-mentioned items were provided during the post audit phase. No further action is needed.

Standard 115.334: Specialized training: Investigations

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

115.334 (a)

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

115.334 (b)

- Does this specialized training include techniques for interviewing juvenile sexual abuse victims? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☐ Yes ☐ No ☒ NA

- Does this specialized training include proper use of Miranda and Garrity warnings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☐ Yes ☐ No ☒ NA

- Does this specialized training include sexual abuse evidence collection in confinement settings? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☐ Yes ☐ No ☒ NA

- Does this specialized training include the criteria and evidence required to substantiate a case for administrative action or prosecution referral? (N/A if the agency does not conduct any form of administrative or criminal sexual abuse investigations. See 115.321(a).) ☐ Yes ☐ No ☒ NA

115.334 (c)

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

115.334 (d)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy & Procedures, *Specialized Training: Investigations/Medical and Mental Health*
    c. Specialized Training for PREA Investigator Certificate -2
2. Interviews:
    a. Executive Director – 1
    b. Investigators - 2

Findings (By Provision):

115.334 (a). As indicated in the PAQ, agency indicated NA that they do not require that investigative staff are trained in conducting sexual abuse investigations in confinement settings. Policy & Procedures, *Specialized Training: Investigations/Medical and Mental Health*, states that "the facility requires that investigators are trained in conducting sexual abuse investigations in confinement settings. The facility conducts administrative investigations, not criminal investigations" (*p.1*). However, after further review, it was determined that the facility conducts administrative investigations; therefore, the auditor recommended that the designated Woodward staff complete the specialized training.

Documentation Reviewed

Specialized Training for PREA Investigator Certificate-2

Interviews

Investigator: The facility has two identified investigators. Both staff were interviewed and reported receiving general PREA training. One investigator reported receiving training several years ago on completing investigations however it was not specific to PREA investigations.

Based on review of documents and interviews, it was identified that the facility did not have any investigators trained on conducting sexual abuse investigations. It is the auditor's recommendation that both investigators complete the specialized training hosted by the National Institute of Corrections (NIC). The facility completed the corrective action.

115.334 (b). As previously stated, Woodward Academy does not conduct administrative investigations. Policy & Procedures, *Specialized Training: Investigations/Medical and Mental Health*, states that "specialized training includes but is not limited; 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" (*p. 2*).

Documentation Reviewed
Specialized Training for Investigators NIC Curriculum
Specialized Training for PREA Investigator Certificate-2

Interviews

Investigative Staff: The interviewed investigators reported that they were not trained on the above-mentioned topics. One investigator reported that they received training on how to preserve the crime

scene and one investigator reported that they received training on how to establish questions to gain the facts that you are looking for.

Based on review of documents and interviews, it was identified that the facility did not have any investigators trained on conducting sexual abuse investigations. It is the auditor's recommendation that both investigators complete the specialized training hosted by the National Institute of Corrections (NIC). The facility provided proof that two designated staff received the required training. There are no additional requirements of the provision. The corrective action was addressed.

115.334 (c). As indicated in the PAQ, the facility does not conduct administrative investigations. After further review Policy & Procedures, *Specialized Training: Investigations/Medical and Mental Health*, states that "the facility requires that investigators are trained in conducting sexual abuse investigations in confinement settings. The facility conducts administrative investigations, not criminal investigations" (*p.1*).

Documentation Reviewed
Specialized Training for Investigators NIC Curriculum
Specialized Training for PREA Investigator Certificate-2

Corrective Action:
The facility shall provide a copy of the specialized training certificates for onsite investigators. The documentation was provided during the onsite audit phase. There is no further action needed. The facility is compliance with the standard.

Standard 115.335: Specialized training: Medical and mental health care

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

115.335 (a)

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

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How to preserve physical evidence of sexual abuse? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.) ☒ Yes ☐ No ☐ NA

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

- Does the agency ensure that all full- and part-time medical and mental health care practitioners who work regularly in its facilities have been trained in: How and to whom to report allegations

or suspicions of sexual abuse and sexual harassment? (N/A if the agency does not have any full- or part-time medical or mental health care practitioners who work regularly in its facilities.)
☒ Yes ☐ No ☐ NA

115.335 (b)

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

115.335 (c)

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

115.335 (d)

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

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
   a. Pre-Audit Questionnaire (PAQ)

b. Policy:
    i. PREA Zero Tolerance
    ii. Policy & Procedures, *Specialized Training: Investigations/Medical and Mental Health*
c. PREA 201 for Medical and Mental Health Practitioners, Presented by the National Institute of Corrections– 9
d. NIC PREA 201 for Medical and Mental Health Practitioners, Presented by the National Institute of Corrections Curriculum
e. Medical Health Care for Sexual Assault Victims in a Confinement Setting Training-3

2. Interviews:
    a. Medical and mental health staff - 2

Findings (By Provision):

115.335 (a). As reported in the PAQ, there are 8 medical and mental health staff who work regularly at the facility, have received the training required by policy. Policy & Procedures, *Specialized Training: Investigations/Medical and Mental Health,* states that the facility will ensure that all full-time, part-time, and contingent on-call medical and mental health care practitioners have been trained in:

1. How to detect and assess signs of sexual abuse and sexual harassment.
2. How to preserve physical evidence of sexual abuse.
3. How to respond effectively and professionally to resident victims of sexual abuse and sexual harassment; and
4. How, and to whom, to report allegations or suspicions of sexual abuse and sexual harassment *(p. 1)*.

It was determined that the facility medical and mental health staff did not have documentation that they had completed the specialized training for medical and mental health practitioners. During the post audit phase, the auditor reviewed nine medical and mental health training records, showing completing of the specialized training.

Documentation Reviewed

- PREA 201 for Medical and Mental Health Practitioners, Presented by the National Institute of Corrections– 9
- NIC PERA 201 for Medical and Mental Health Practitioners, Presented by the National Institute of Corrections Curriculum

Interviews

Medical and Mental Health Staff: All of the interviewed staff were able to provide evidence of training to support their knowledge and understanding to detect sings of sexual abuse, professionally interact with victims, preserve physical evidence, as well as perform health care reporting documentation responsibilities. The interviewed mental health staff further reported that over the last 25 years I have competed several continuing education hours for the maintenance of my current license as well for professional purposes. Several of these classes have surrounded trauma focused treatment that have included areas of victimization that encompasses sexual abuse and sexual harassment.

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

115.335 (b). The Woodward Academy facility does not conduct forensic medical examinations. Interviews with the medical and mental health staff, further confirmed that they are not trained to conduct such examinations. Policy *PREA Zero Tolerance* states that "if the assault is alleged to have occurred within the past 96 hours, the victim must be transported to Dallas County Hospital (Perry, IA) or Blank Children's Hospital (Des Moines, IA) (or alternate if directed by Administration or emergency personnel) for examination by qualified personnel for collection of physical evidence. If the assault is alleged to have occurred more than 96 hours previous, the hospital is contacted for instructions" (p. 6).

Documentation Reviewed

- PREA 201 for Medical and Mental Health Practitioners, Presented by the National Institute of Corrections– 9
- NIC PERA 201 for Medical and Mental Health Practitioners, Presented by the National Institute of Corrections Curriculum

Interviews

Medical and Mental Health Staff: The interviewed medical and mental health staff reported that they do not conduct forensic examinations.

Corrective Action: It was determined that the facility medical and mental health staff did not have documentation that they had completed the specialized training for medical and mental health practitioners. During the post audit phase, the auditor reviewed nine medical and mental health training records, showing completing of the specialized training.

115.335 (c). As reported in the PAQ, the facility maintains training records of the medical and mental health staff. After further review, it was not determined that the medical and mental health staff completed any specialized training therefore the facility went into corrective action to address the provision.

Documentation Reviewed

- PREA 201 for Medical and Mental Health Practitioners, Presented by the National Institute of Corrections– 9
- NIC PERA 201 for Medical and Mental Health Practitioners, Presented by the National Institute of Corrections Curriculum

During the post audit phase, the auditor reviewed nine medical and mental health training records, showing completing of the specialized training.

Corrective Action:

The following items are pending and will need to be provided in order to determine compliance:

- The facility shall provide a copy of the specialized training certificates for onsite medical and mental health staff.

During the post audit phase, the auditor reviewed nine medical and mental health training records, showing completing of the specialized training. There is no further action required. The facility is now in compliance with the standard.

SCREENING FOR RISK OF SEXUAL VICTIMIZATION AND ABUSIVENESS

Standard 115.341: Screening for risk of victimization and abusiveness

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

115.341 (a)

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

- Does the agency also obtain this information periodically throughout a resident's confinement? ☒ Yes ☐ No

115.341 (b)

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

115.341 (c)

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (1) Prior sexual victimization or abusiveness? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (2) Any gender nonconforming appearance or manner or identification as lesbian, gay, bisexual, transgender, or intersex, and whether the resident may therefore be vulnerable to sexual abuse? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (3) Current charges and offense history? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (4) Age? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (5) Level of emotional and cognitive development? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (6) Physical size and stature? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (7) Mental illness or mental disabilities? ☒ Yes ☐ No
- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (8) Intellectual or developmental disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (9) Physical disabilities? ☒ Yes ☐ No

- During these PREA screening assessments, at a minimum, does the agency attempt to ascertain information about: (10) The residents' own perception of vulnerability? ☒ Yes ☐ No

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

115.341 (d)

- Is this information ascertained through conversations with the resident during the intake process and medical mental health screenings? ☒ Yes ☐ No

- Is this information ascertained during classification assessments? ☒ Yes ☐ No
- Is this information ascertained by reviewing court records, case files, facility behavioral records, and other relevant documentation from the resident's files? ☒ Yes ☐ No

115.341 (e)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        i. Medical Services (tab 14)
        ii. Prison Rape Elimination Act "PREA"
        iii. Pre-Screening and Use of Information
    c. Resident Files (20):
        i. PREA Assessment (tab12)

ii. Psychosocial Assessment (tab 13)
iii. *Nurse Intake Assessment Form* – 20
iv. Housing Placement-20
v. Parent Student Handbook (tab 14)

2. Interviews:
    a. Staff responsible for Risk Screening - 1
    b. Random sample of residents - 20
    c. PREA coordinator
    d. PREA compliance manager

Findings (By Provision):

115.341 (a). As reported in the PAQ, the agency has a policy that requires screening (upon admission to a facility or transferred to another facility) for risk of sexual abuse victimization or sexual abusiveness toward other residents. The PAQ further indicated that the policy requires that residents be screened for risk of sexual victimization or risk of sexual abusing other residents within 72 hours of their intake. The Prison Rape Elimination Act "PREA" policy states that the student assessment will occur during orientation within 48 hours of admission. The policy further states that the "review will be used to determine the student's potential risk of sexual vulnerability based on the following need factors:

a. Age,
b. Physical Stature,
c. Mental Illness,
d. Sex Offender Status (prior offense history),
e. First-time Offender Status,
f. Past History of Victimization,
g. Physical disabilities and the student's own perception of vulnerabilities.

Additionally, the policy states that the "student must be evaluated as part of orientation to determine if the student is prone to victimize other student, especially in regard to sexual behavior, based on the following risk factors:

a. History of sexually aggressive behavior.
b. History of violence as related to sexual offense.
c. Anti-social attitudes indicative of a sexually aggressive behavior.

Documents Reviewed:

- A review of 20 resident files, confirmed that residents are screened within the time frames of this standard.

<u>Interviews</u>

Staff Responsible for Risk Screening: One staff responsible for risk screening was interviewed. The staff reported that upon admission a risk of sexual abuse victimization or sexual abusiveness (PREA Assessment) is completed immediately but no later than within 72 hours of arrival at the facility. The information is ascertained by talking with the youth and reviewing records. The information is assessed only upon admission formally.

Random Sample of Residents: Eighteen of the 20 interviewed residents have been at the facility for less than 12 months. A majority residents stated they were asked about sexual orientation, disabilities and if they felt safe at the facility during intake. Most of the residents reported that the nursing staff asked the questions. The residents could not consistently recall whether or not they have been asked the same questions again.

A review of 20 records of residents who entered the facility in the last 12 months provided evidence that the appropriate screenings occur within 72 hours. There are multiple screening tools utilized. One is called the *Nurse Intake Assessment for Residential Care* and the other is the *PREA Intake Assessment Form*; and 100% of the intake screening forms were completed within one day; hence exceeding the standards.

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

115.341 (b). The PAQ indicated that the Woodward Academy facility utilizes a risk assessment that is an objective screening instrument called a *PREA Intake Assessment Form*. Twenty of the forms were reviewed by the auditor. The form provides a point value system to each question, based on how the resident responds. A review of the appropriate documentation and relevant policies indicates that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

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

Interviews

Staff Responsible for Risk Screening: The interviewed staff responsible for risks screenings, reported that the tool looks at history of sexual offenses, age, prior abuse, mental illness/cognitive ability, and prior placements.

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

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

Interviews

Staff Responsible for Risk Screening: The interviewed staff responsible for risk screening, reported that they attain the information through conversation and review records.

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

115.341 (e). As previously stated, Policy & Procedures, *Pre-Screening, and Use of Information*, states that, “in utilizing a Behavior Support Plan, the facility provides appropriate controls on the dissemination of the plan within the facility. This will update the resident ’s risk level periodically throughout their confinement. In distribution, all staff are notified that the material contained within is sensitive information and is not exploited to the resident ’s detriment by staff or any other resident. This information is to remain confidential by all receiving staff” *(p. 1)*.

Interviews

Staff Responsible for Risk Screening: The interviewed staff responsible for performing the screening for risk of victimization and abusiveness reported that the resident’s risk assessment is only available to the nurses, clinical team, and the QA department.

PREA compliance manager: The interviewed PREA compliance manager reported that the facility limits who has access to the resident's risk screening. The communication occurs between nursing, management, and clinical teams to decide the safest place for a student. They try to keep students of the same age in each room. The PCM was unsure on how can have access to the resident's risk assessment.

PREA Coordinator: The interviewed PREA coordinator stated that the agency and its facilities are "covered entities" under HIPAA, the strictest "minimum necessary" standards are followed, consistent with policy, law, and regulation. Only staff who require certain information to execute their duties in the delivery of care, treatment, and services are permitted to access relevant information.

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

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.342: Use of screening information

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

115.342 (a)

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

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

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

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

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

115.342 (b)

- Are residents isolated from others only as a last resort when less restrictive measures are inadequate to keep them and other residents safe, and then only until an alternative means of keeping all resident's safe can be arranged? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

- During any period of isolation, does the agency always refrain from denying residents daily large-muscle exercise? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

- During any period of isolation, does the agency always refrain from denying residents any legally required educational facility programming or special education services? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

- Do residents in isolation receive daily visits from a medical or mental health care clinician? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

- Do residents in isolation also have access to other facilities and work opportunities to the extent possible? (N/A if the facility *never* places residents in isolation for any reason.) ☒ Yes ☐ No ☐ NA

115.342 (c)

- Does the agency always refrain from placing lesbian, gay, and bisexual (LGB) residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing transgender residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from placing intersex residents in particular housing, bed, or other assignments solely on the basis of such identification or status? ☒ Yes ☐ No

- Does the agency always refrain from considering lesbian, gay, bisexual, transgender, or intersex (LGBTI) identification or status as an indicator or likelihood of being sexually abusive? ☒ Yes ☐ No

115.342 (d)

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

- When making housing or other facility assignments for transgender or intersex residents, does the agency consider, on a case-by-case basis, whether a placement would ensure the resident's health and safety, and whether a placement would present management or security problems? ☒ Yes ☐ No

115.342 (e)

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

115.342 (f)

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

115.342 (g)

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

115.342 (h)

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

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

115.342 (i)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

facility does not meet the standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.
The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        i. Prison Rape Elimination Act "PREA"
    c. Resident Files (20):
        i. PREA Assessment (tab12)
        ii. PREA Reassessment
        iii. Psychosocial Assessment (tab 13)
        iv. *Nurse Intake Assessment Form* – 20
        v. Housing Placement-20
        vi. Parent Student Handbook (tab 14)
2. Interviews:
    a. PREA compliance manager
    b. PREA coordinator
    c. Staff responsible for Risk Screening - 1
    d. Executive Director
    e. Medical and mental health staff - 2
    f. Randomly selected staff – 13
    g. LGBTI Resident- 3
3. Onsite Tour
    a. Review of housing units

Findings (By Provision):
115.342 (a). As stated in the PAQ, the Woodward Academy facility, uses information from the risk screening to inform housing, bed, work, education, and facility assignment with the goal of keeping the resident safe and free from sexual abuse. The *Prison Rape Elimination Act "PREA"* policy states that, "Woodward Academy must use all information obtained to make housing, bed, program, education and work assignments for students with the goal of keeping student's safe and free from sexual abuse" (*p. 4*).

<u>Documentation Reviewed</u>

- Upon review of 20 resident files, it was identified that the facility utilizes a comprehensive approach to access clients and make uniformed housing decisions based on the needs. During the onsite inspection, the facility staff also showed how residents are separated based on history of victimization, perpetration, and/or trauma triggers.

<u>Interviews</u>
PREA Compliance Manager: The interviewed PREA compliance manager indicated that facility would take information from the screening to determine a resident's physical stature, sexualized behaviors, age, and other factors.

Staff Responsible for Risk Screening: The interviewed staff responsible for the risk screening reported that the information from the risk screening is reported to the clinicians, supervisors and management.

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

The *Prison Rape Elimination Act "PREA"* policy states that, "a student may be separated from other students as a preventative and protective measure, but only as a last resort when other less restrictive measures are inadequate to keep the student safe from other students, and then only until an alternate means of keeping all students safe can be arranged" (*p. 5*).

Interviews

Director: The director also confirmed that the facility does not use isolation. The residents would be separated for any safety concerns until we are able to identify and appropriate safety plan.

Medical and Mental Health Staff: The interviewed mental health and medical staff reported that isolation is not used at the facility. The youth will continue with all student rights due to their placement within our treatment program.

It should be noted that there were no reported residents placed in isolation who were at risk of sexual victimization. A review of the appropriate documentation, interviews with staff, and review of relevant policies indicate that the facility is in compliance with the provisions of this standard. No corrective action is warranted.

115.342 (c). As reported in the PAQ, the facility prohibits placing lesbian, gay, bisexual, or intersex residents in particular housing, bed, or other assignments solely on the basis of such identification status. The *Prison Rape Elimination Act "PREA"* policy states that "lesbian, gay, bisexual, transgender or intersex (LGBTI students may not be housed solely on the basis of such identification or status" (*p. 4*). Policy PREA Zero Tolerance further describes that "llesbian, gay, bisexual, transgender or intersex (LGBTI) clients may not be housed solely on the basis of such identification or status. In addition, the facility must:

a. Decide on a case-by-case basis whether to place a transgender or intersex client in a facility for male or female clients.
b. Placement decisions are based on whether the placement would ensure the client health and safety and whether the placement would present management or security problems. The client own view of his/her gender identity should be considered when determining placement.
c. Review placement and programming assignments at least twice each year to assess any threats to safety experienced by the client. Every 30 days when client has been housed separately due to having less restrictive alternatives to keep client safe.
d. Allow transgender and intersex clients the opportunity to shower separately from other clients" (*p*. 3).

Documentation Reviewed

- Upon review of 20 resident housing forms, there was no indication that residents are placed in special housing based on their sexual orientation.

Interviews

PREA Coordinator: The interviewed PREA Coordinator reported that the facility does not use special housing for lesbian, gay, bisexual, transgender or intersex residents.

PREA Compliance Manager: The interviewed PREA compliance manager reported that the facility does not have special housing unit (s) for lesbian, gay, bisexual, transgender or intersex residents.

LGBTQI Residents: Three residents interviewed that identified as lesbian, gay, or bisexual. The resident reported that there is no special housing area for gay, lesbian, bisexual, transgender, or intersex residents. Review of the intake and housing assignments found that there was no evidence that rooming decisions were made based on a resident identifying as gay, lesbian, bisexual, transgender, or intersex residents.

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

115.342 (d). As reported in the PAQ, the facility makes housing and facility assignments for transgender or intersex residents in a facility on a case-by-case basis. As previously stated, the facility policy will make assignment decisions for transgender or intersex residents on a case by case. Policy Prison Rape Elimination Act "PREA", states that, lesbian, gay, bisexual, transgender or intersex (LGBTI) residents may not be housed solely on the basis of such identification or status. In addition, Woodward Academy must:

a. Decide on a case-by-case basis whether to place a transgender or intersex student in a facility for male students.
b. Placement decisions are based on whether the placement would ensure the student's health and safety and whether the placement would present management or security problems. The student's own view of his/her gender identity should be considered when determining placement.
c. Review placement and facility programming assignments at least twice each year to assess any threats to safety experienced by the student.
d. Allow transgender and intersex students the opportunity to shower separately from other students. *(pp. 4-5)*.

Interviews

PREA Compliance Manager: The interviewed PREA compliance manager stated that the placement is based on biological sex.

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

115.342 (e). The *Prison Rape Elimination Act "PREA"* policy states that, the facility will "review placement and programming assignments at least twice each year to assess any threats to safety experienced by the student" *(p 4).*

Interviews

PREA Compliance Manager: The interviewed PREA compliance manager stated that the facility will take into consideration and assess for safety.

Staff Responsible for Risk Screening: The interviewed staff responsible for risk screening stated that safety considerations are made for transgender or intersex residents would be taken into consideration. Furthermore, all resident's safety concerns are taken seriously.

115.342 (f). The *Prison Rape Elimination Act "PREA"* policy states that, states that, the facility placement and facility programming assignments for each transgender, or intersex residents will be reassessed at least twice each year to review any threats to safety experienced by the resident. During the reassessment, transgender and intersex residents own views will be given serious consideration with respect to his or her own safety *(p. 4)*.

Interviews

PREA Compliance Manager: The interviewed PREA compliance manager reported that the Woodward Academy staff shall take into consideration a transgender or intersex resident's own view with respect to his or her own safety. They don't want to put a student in an environment that would jeopardize their security.

Staff Responsible for Risk Screening: The interviewed staff responsible for screening stated that transgender or intersex residents' views for their own safety would be taken into consideration. Consideration would be based on each youth's situation.

There were no identified transgender or intersex residents.

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

115.342 (g). The *Prison Rape Elimination Act "PREA"* policy states that, states that the facility will "aallow transgender and intersex residents the opportunity to shower separately from other students" *(p. 5)*. It should be noted that all youth at the facility shower separately.

Interviews

PREA Compliance Manager: The interviewed PCM stated that they have never admitted a student who is transgender. If they did, it would be reviewed twice a year.

Staff Responsible for Risk Screening: One of the interviewed staff responsible for risk screening stated that if a screening indicates that a resident has experienced prior sexual victimization whether in an institutional setting or in the community; follow up medical or mental health services would be offered. This would occur at the local hospital immediately.

Transgender or Intersex Resident: There were no identified transgender or intersex residents.

115.342 (h). The PAQ, indicated that there were zero residents at risk of sexual victimization who were held in isolation in the past 12 months as isolation is not utilized. As reported by the PREA compliance manager there were no residents placed in isolation that were at risk for sexual victimization.

115.342 (i). Woodward Academy does not utilize isolation.

Corrective Action:
No corrective action is recommended for this standard.

REPORTING

Standard 115.351: Resident reporting

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

115.351 (a)

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

115.351 (b)

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

115.351 (c)

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

115.351 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        a. Prison Rape Elimination Act "PREA"
        b. PREA Zero Tolerance Policy
        c. PREA First Responder and Grievance
    c. Student Information:
        a. PREA Student Orientation Packet
        b. PREA Poster (Spanish/English)
    d. PREA brochure (What you should know about Sexual Assault/Abuse) (Spanish/English)
    e. Allegations of Sexual Abuse or Sexual Harassment (11)
    f. Staff PREA Training
    g. *Client Grievances (12-month sample)*
2. Interviews:
    a. Random sample of staff - 12
    b. Random sample of residents - 20
    c. PREA compliance manager
    d. Reported sexual abuse - 4

Findings (By Provision):

115.351 (a). As reported in the PAQ, the Woodward Academy facility has established procedures allowing multiple internal ways for residents to privately report sexual abuse or sexual harassment. Policy *Prison Rape Elimination Act "PREA"*, describes multiple ways in which a resident can report PREA; which includes, but is not limited to verbally, grievance, anonymously, third-party reporting, and reporting to a private entity or Children's Protected Services *(p. 6)*.

Documentation Reviewed

- Upon review of the PREA Student Orientation Packet it was observed that residents are provided information on multiple ways to report allegations of sexual abuse and sexual harassment. The packet stated that students may report to staff, supervisors, or administrators or may report to someone outside of the facility by calling Children's Protective Services at 1800-362-2178.
- The auditor reviewed 12 allegations of sexual abuse or sexual harassment that occurred in the last 12 months. Upon review it was identified that any allegations that were verbally made, where immediately reported and investigated. There was one allegation where a staff member observed

inappropriate boundaries and delayed reporting. The staff member resigned during the course of the investigation.

Interviews

Random Sample of Staff: The 12 interviewed random sample of staff reported that the residents can report any sexual abuse or sexual harassment by using the hotline number, notify staff, supervise, parent or complete grievance process. All the interviewed staff reported that if a resident makes a report verbally or in writing, sexual abuse or harassment, the allegations are responded to immediately and they would immediately contact supervisor.

Random Sample of Residents: All of interviewed residents stated that they had multiple ways to report. Most of the residents reported that they write a grievance, tell staff, tell higher ups, call DHS, or call the hotline.

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

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

115.351 (b). As reported in the PAQ, the Woodward Academy facility provides more than one way for residents to report abuse or harassment to a public or private entity that is not part of the agency. Policy *Prison Rape Elimination Act "PREA"*, describes multiple ways in which a resident can report PREA; which includes, but is not limited to verbally, grievance, anonymously, third-party reporting, and reporting to a private entity or Children's Protected Services *(p. 6)*.

Documentation Reviewed:

- Upon review of the PREA Student Orientation Packet it was observed that residents are provided information on multiple ways to report allegations of sexual abuse and sexual harassment. The packet stated that students may report to staff, supervisors, or administrators or may report to someone outside of the facility by calling Children's Protective Services at 1800-362-2178.
- The auditor reviewed 12 allegations of sexual abuse or sexual harassment that occurred in the last 12 months. Upon review it was identified that any allegations that were verbally made, where immediately reported and investigated. There was one allegation where a staff member observed inappropriate boundaries and delayed reporting.
- While the facility may not have a formal agreement with outside entities to receive allegations of of sexual abuse or sexual harassment, the auditor observed through the 12 investigations a process where local CPS received and conducted investigations related to sexual abuse or sexual harassment at the Woodward Academy.

Interviews

Random Sample of Residents: When interviewing the 20 residents at the facility, it was reported that the facility has provided residents with the ability to contact a private and public entity outside of Woodward Academy. The residents reported that they could call 911, call DHS, tell family, or call the hotline. All but three of the residents stated that they believe they could make a report without having to give their name.

PREA compliance manager: The interviewed PREA compliance manager further reiterated that facility has postings in each dorm with a number to call to make a report without involving Woodward Academy staff. The PCM was unsure if the procedure enabled receipt and immediate transmission of resident

reports of sexual abuse and sexual harassment to agency officials which allows the resident to remain anonymous.

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

115.351 (c). The facility reported in the PAQ, that there is a policy mandating staff to accept reports of sexual abuse or sexual harassment made verbally, in writing, anonymously and from third parties. Policy *Prison Rape Elimination Act "PREA"*, further reiterates said requirements *(p. 2)*. It was further reported that staff are required to document verbal reports within 72 hours. Additionally, staff are required to document the reports immediately. The student orientation handbook describes multiple means for residents to report. Such means include verbally, in writing, anonymously, and from third parties. As previously discussed, the residents were able to describe being able to make reports verbally, in writing, anonymously, and from third parties.

Documentation Reviewed

- Upon review of the PREA Student Orientation Packet it was observed that residents are provided information on multiple ways to report allegations of sexual abuse and sexual harassment. The packet stated that students may report to staff, supervisors, or administrators or may report to someone outside of the facility by calling Children's Protective Services at 1800-362-2178.
- The auditor reviewed 12 allegations of sexual abuse or sexual harassment that occurred in the last 12 months. Upon review it was identified that any allegations that were verbally made, where immediately reported and investigated. There was one allegation where a staff member observed inappropriate boundaries and delayed reporting.

Interviews

Random Sample of Staff: Twelve interviewed random staff understood that residents are allowed to make report verbally or written by telling a staff, director or writing a grievance if they needed to report sexual abuse or sexual harassment for themselves or another resident. The staff also understood they are mandated reporters and expected to report this information immediately to supervisor. It should be noted that one staff member reported that they are not aware of how third-party reports are handled.

Random Sample of Residents: Twenty interviewed residents stated that they understood they could make a report verbally or written by telling staff if they needed to report sexual abuse or sexual harassment for themselves or another resident. All of the interviewed residents knew that someone else could make the report on their behalf, so that would not have to give their name.

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

115.351 (d). As reported in the PAQ, the facility provides residents with access to tools to make written reports of sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents. Policy PREA Zero Tolerance states that "the client may request such action in writing via the grievance procedure. The client may also request to speak with the PREA Compliance Manager and/or Program Representative. The PREA Compliance Manager and or Program Representative will facilitate the call. The call is confidential. The PREA Compliance Manager and/or Program Representative will not listen to the client's report but will keep the client within direct line of sight" (*p*. 4).

Documentation Reviewed:

- The auditor reviewed residents access to phone lines and the ability to complete a grievance. During the onsite inspection the auditor observed residents on telephone calls and provided reasonable access to privacy while on their phone calls.

Interviews

PREA Compliance Manager: The PCM reported that the facility provides residents with tools to help them make written reports of sexual abuse or sexual harassment, retaliation by other residents or staff for reporting sexual abuse and sexual harassment. There are postings on each dorm explaining how to make a report. Students are also aware of the grievance procedure and how they could make a report.

Residents Who Reported Sexual Abuse: Four residents were interviewed that reported a prior history of sexual abuse. Only one resident reported that someone at the facility assisted him with making a report. The staff provided them with the document needed to write a report.

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

115.351 (e). The facility indicated in their response to the Pre-Audit Questionnaire that the agency has established procedures for staff to privately report sexual abuse and sexual harassment of residents. Policy *PREA First Response and Grievance* states that, "The facility will provide a method for staff to privately report sexual abuse and sexual harassment of residents" *(p.* 4).

It was also reported that staff are informed of these procedures through policy and training materials. In review of the staff PREA training, such information is provided to staff.

Interviews

Random Sample of Staff: The 12 interviewed staff reported that they could privately report sexual abuse and sexual harassment to supervisor, send email to director, call the PREA hotline or contact local law enforcement.

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

Corrective Action:
The following items are pending and will need to be provided in order to determine compliance:

- Need a sample of grievances filed over the last 12 months to include all grievances associated with sexual abuse or sexual harassment. A 12-month sample of grievances were provided. There is no further action needed.

Standard 115.352: Exhaustion of administrative remedies

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

115.352 (a)

- Is the agency exempt from this standard? NOTE: The agency is exempt ONLY if it does not have administrative procedures to address resident grievances regarding sexual abuse. This does not mean the agency is exempt simply because a resident does not have to or is not ordinarily expected to submit a grievance to report sexual abuse. This means that as a matter of

explicit policy, the agency does not have an administrative remedies process to address sexual abuse. ☐ Yes ☒ No

115.352 (b)

- Does the agency permit residents to submit a grievance regarding an allegation of sexual abuse without any type of time limits? (The agency may apply otherwise-applicable time limits to any portion of a grievance that does not allege an incident of sexual abuse.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency always refrain from requiring a resident to use any informal grievance process, or to otherwise attempt to resolve with staff, an alleged incident of sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (c)

- Does the agency ensure that: A resident who alleges sexual abuse may submit a grievance without submitting it to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency ensure that: Such grievance is not referred to a staff member who is the subject of the complaint? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (d)

- Does the agency issue a final agency decision on the merits of any portion of a grievance alleging sexual abuse within 90 days of the initial filing of the grievance? (Computation of the 90-day time period does not include time consumed by residents in preparing any administrative appeal.) (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If the agency determines that the 90-day timeframe is insufficient to make an appropriate decision and claims an extension of time [the maximum allowable extension of time to respond is 70 days per 115.352(d)(3)], does the agency notify the resident in writing of any such extension and provide a date by which a decision will be made? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- At any level of the administrative process, including the final level, if the resident does not receive a response within the time allotted for reply, including any properly noticed extension, may a resident consider the absence of a response to be a denial at that level? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (e)

- Are third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, permitted to assist residents in filing requests for administrative remedies relating to allegations of sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

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

- If the resident declines to have the request processed on his or her behalf, does the agency document the resident's decision? (N/A if agency is exempt from this standard.)
  ☒ Yes ☐ No ☐ NA

- Is a parent or legal guardian of a juvenile allowed to file a grievance regarding allegations of sexual abuse, including appeals, on behalf of such juvenile? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- If a parent or legal guardian of a juvenile files a grievance (or an appeal) on behalf of a juvenile regarding allegations of sexual abuse, is it the case that those grievances are not conditioned upon the juvenile agreeing to have the request filed on his or her behalf? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (f)

- Has the agency established procedures for the filing of an emergency grievance alleging that a resident is subject to a substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance alleging a resident is subject to a substantial risk of imminent sexual abuse, does the agency immediately forward the grievance (or any portion thereof that alleges the substantial risk of imminent sexual abuse) to a level of review at which immediate corrective action may be taken? (N/A if agency is exempt from this standard.).
  ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency provide an initial response within 48 hours? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- After receiving an emergency grievance described above, does the agency issue a final agency decision within 5 calendar days? (N/A if agency is exempt from this standard.)
  ☒ Yes ☐ No ☐ NA

- Does the initial response and final agency decision document the agency's determination whether the resident is in substantial risk of imminent sexual abuse? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the initial response document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

- Does the agency's final decision document the agency's action(s) taken in response to the emergency grievance? (N/A if agency is exempt from this standard.) ☒ Yes ☐ No ☐ NA

115.352 (g)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        a. Grievance Procedure
        b. Prison Rape Elimination Act "PREA"
        c. Student/Family Concern Grievance Procedure (tab 14)
        d. PREA Zero Tolerance
    c. *Client Grievance (Sample of last 12 months)*
    d. Parent Student Handbook
    e. PREA Student Orientation Packet
2. Interviews:
    a. Residents who reported sexual abuse - 4
    b. DYS Advocates

Findings (By Provision):

115.352 (a). As reported in the PAQ, the agency has an administrative process for dealing with resident grievances regarding sexual abuse and is not exempt from this standard. The Woodward Academy *Student/Family Concern Grievance policy* provides guidance on how resident grievances are managed. The policy states that, "it is recognized that there will be times when clients will have grievances, which they wish to have evaluated and/or addressed by the program. Policy PREA Zero Tolerance states that "the client may request such action in writing via the grievance procedure. The client may also request to speak with the PREA Compliance Manager and/or Program Representative. The PREA Compliance Manager and or Program Representative will facilitate the call. The call is confidential. The PREA Compliance Manager and/or Program Representative will not listen to the client's report but will keep the client within direct line of sight" (*p*. 4).

<u>Documentation Reviewed</u>

- The PREA Student Orientation Packet provides the residents and the parents with the facility grievance procedure.

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

115.352 (b). As reported in the PAQ, the Woodward Academy facility reported that the agency does not require a resident to use an informal grievance process, or otherwise to attempt to resolve with staff, an alleged incident of sexual abuse. Policy *PREA Zero Tolerance* states that:

1. The facility shall not impose a time limit on when a resident may submit a grievance regarding an allegation of sexual abuse.
2. The facility may apply otherwise-applicable time limits on any portion of a grievance that does not allege an incident of sexual abuse.
3. The facility 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 *(p.8*).

Documentation Reviewed

- The PREA Student Orientation Packet provides the residents and the parents with the facility grievance procedure.
- The *Parent Student Handbook* provides further guidance to the residents on their ability to file grievances for allegations of sexual abuse and sexual harassment.

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

115.352 (c). As reported in the PAQ, the agency has policy and procedures that allow residents to submit a grievance and not have to send the grievance to the staff member who is subject of the complaint. Policy *PREA Zero Tolerance*, states that, "the facility shall not require a client to use any informal grievance process, or to otherwise attempt to resolve with staff an alleged incident of sexual abuse" *(p. 8)*.

Documentation Reviewed

- The PREA Student Orientation Packet provides the residents and the parents with the facility grievance procedure.
- The *Parent Student Handbook* provides further guidance to the residents on their ability to file grievances for allegations of sexual abuse and sexual harassment.

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

115.352 (d). As reported in the PAQ, the agency policy and procedure require that a decision on the merits of any grievance or portion of a grievance alleging sexual abuse be made within 90 days of the filing of the grievance. There have been zero reported grievances filed that alleges sexual abuse. The Student/Family Concerns Grievance policy states that emergency grievances shall be addressed within 72 hours. Policy Prison Rape Elimination Act "PREA" states that "Woodward Academy may issue a final decision (initial decision and appeal decision if appealed) on the merits of a grievance alleging sexual abuse or harassment within 90 days of the initial filing of the grievance" (*p. 14*)

Interviews

Residents who Reported a Sexual Abuse: Two of the four interviewed residents who reported sexual abused stated that they were notified of the results of the incident. One resident stated that he was told verbally, and one resident stated that he was provided something in writing. It should also be noted that the resident stated that he was told verbally recalled signing a form about the results of the incident.

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

115.352 (e). As reported in the PAQ, the agency policy and procedure does not permit third parties, including fellow residents, staff members, family members, attorneys, and outside advocates, to assist

residents in filing a request for administrative remedies relating to allegations of sexual abuse and to file such requests on behalf of residents. However, Policy Prison Rape Elimination Act "PREA", stated that,

> Third parties, including fellow students, staff, family, attorneys, and outside advocates may assist a student filing grievance relating to allegations of sexual abuse and harassment. If a third party, other than the parent or guardian, files a grievance on the student's behalf, the facility must request as a condition of processing that the alleged victim agree to, the grievance filed on his behalf and may also require that the alleged victim pursue any subsequent steps in the remedy process. If the alleged victim declines to have the grievance processed on his behalf, the facility must document the student's decision.

Documentation Reviewed

- The *Parent Student Handbook* states that "students have a right to communicate with their referring worker. Students will have access to their attorney or referring worker without discussing the reason (s) for that contact" (*p. 4*).
- Upon review of 12 allegations of sexual abuse and/or sexual harassment there were no identified 3rd party reports.

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

115.352 (f). Per the PAQ, there were zero emergency PREA grievances filed in the past 12 months. The Woodward Academy *Student/Family Concern Grievance policy* provides guidance on how resident can file an emergency grievance. The policy provides guidelines on who will review the grievance and the timeframe to respond to the grievance.

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

115.352 (g). As reported in the PAQ, the Woodward Academy facility has reported zero number of resident grievances that allege sexual abuse that resulted in disciplinary action by the agency against the resident for having filed the grievances in bad faith. The Woodward Academy *Student/Family Concern Grievance policy* provides guidance that a resident shall not be retaliated against for filling a grievance. There were no identified residents who filed sexual abuse grievances in bad faith.

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

Corrective Action:
The following items are pending and will need to be provided in order to determine compliance:

- Need a sample of grievances filed over the last 12 months to include all grievances associated with sexual abuse or sexual harassment.

The auditor reviewed a sample of grievances over the last 12 months, there were two identified that were PREA related.

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

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

115.353 (a)

- Does the facility provide residents with access to outside victim advocates for emotional support services related to sexual abuse by providing, posting, or otherwise making assessable mailing addresses and telephone numbers, including toll-free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations? ☒ Yes ☐ No

- Does the facility provide persons detained solely for civil immigration purposes mailing addresses and telephone numbers, including toll-free hotline numbers where available of local, State, or national immigrant services agencies? (N/A if the facility *never* has persons detained solely for civil immigration purposes.) ☒ Yes ☐ No ☐ NA

- Does the facility enable reasonable communication between residents and these organizations and agencies, in as confidential a manner as possible? ☒ Yes ☐ No

115.353 (b)

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

115.353 (c)

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

- Does the agency maintain copies of agreements or documentation showing attempts to enter into such agreements? ☒ Yes ☐ No

115.353 (d)

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

- Does the facility provide residents with reasonable access to parents or legal guardians? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        i. Evidence Protocol Forensic Medical Examinations
        ii. Access to emergency medical and mental services
    c. PREA Student Orientation Packet
    d. Access Ames
    e. Blank Children's Star Center
2. Interviews:
    a. Random sample of residents - 20
    b. Executive Director
    c. PREA compliance manager
    d. Residents who reported sexual abuse - 4

Findings (By Provision):

115.353 (a). As reported in the PAQ, The Woodward Academy facility provides residents with access to an outside victim advocate for emotional supportive services related to sexual abuse. While access to the advocates for emotional support was not readily available to the residents, the facility developed posters that were placed throughout the facility, giving residents contact information for advocacy and emotional supportive services. Policy & Procedures, *Evidence Protocol and Forensic Medical Examinations,* states that, "the facility will provide access to a rape crisis center to provide victim advocate services to the student. If a rape crisis center is not available, Woodward Academy will make available a qualified staff member or qualified staff member from a community-based organization. Woodward Academy will document these efforts" *(p. 1)*.

<u>Documentation Reviewed</u>

- The facility provided information on an organization called Access Ames that would provide free and confidential support for victims of sexual abuse. Such services include but not limited to 24-hour crisis line, response, criminal justice advocacy, systems advocacy, community education and training, sexual abuse counseling, and support groups.

<u>Interviews</u>

Random Sample of Residents: Only two of the 20 interviewed residents were able to identify any sexual abuse services available outside of the facility. It should be noted that the residents reported that they were aware of services as they either received them at another program or during private therapy. One resident elaborated that the services included therapy, go to the policy, and a victim advocate. The residents could not recall receiving any information by the facility on outside mailing addresses and telephone numbers. The two residents were not sure if the telephone numbers are toll free, nor where they are sure when they can talk to the outside services. However, the two residents believed that their conversation with the outside services would remain private.

Residents who Reported a Sexual Abuse: One of the four interviewed residents who reported a sexual abuse stated that they received information, mailing address or numbers for any outside services. However, they were able to speak with counselor if they requested. The resident stated that he was given a phone number and was told that staff was there to support. The resident stated that he could call at any time. The resident stated that the conversation is confidential depending on what is discussed. It is hard to always have a private conversation.

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

115.353 (b). As reported in the PAQ, the facility does not inform residents, prior to giving them access to outside support services, the extent to which such communications will be monitored**.** Policy & Procedures, *Access to Emergency Medical and Mental Health Services*, indicates that "medical and mental health practitioners will 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. If a resident is over the age of 18, consent must be obtained by the facility staff prior to reporting sexual abuse that did not occur in an institutional setting" *(p. 2)*.

Interviews

Random Sample of Residents: Two of the twenty residents were aware of outside services. When residents were asked, "Do you think the conversations with people from these services would be told to or listened to by someone else?" Residents stated that they could talk privately.

Residents who Reported a Sexual Abuse: Three of the four residents who reported sexual abused stated that they did not speak with anyone else at the facility or outside services after the incident therefore there were unaware if what they would have told would be shared with others including law enforcement. One resident did state that the local law enforcement took a statement regarding the sexual abuse, no additional information was provided.

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

115.353 (c). As reported in the PAQ, the agency or facility maintains memorandum of understanding (MOUs) or other agreements with community service to providers that can provide residents with emotional support services related to sexual abuse. While the facility does not have an MOU, the facility provided information on a community-based service provider (Access Ames) who can provide emotional support services related to sexual abuse.

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

115.353 (d). As reported in the PAQ, the facility provides residents with reasonable and confidential access to their attorneys or other legal representation, and parents or legal guardians. The *Parent Student Handbook* states that "students have a right to communicate with their referring worker. Students will have access to their attorney or referring worker without discussing the reason (s) for that contact" (*p. 4*).

Interviews

Executive Director (ED): The interviewed ED reported that residents are able to have reasonable and confidential access to their attorneys or legal representation and parents.

PREA Compliance Manager: The interviewed PREA compliance manager reported that residents can talk to their legal representation or parent at any time. There are many residents on each dorm, so they can't always contact their attorney or parent right away when they want too. However, the facility does not limit access to an attorney or parent. If a student wants to speak privately, they are allowed.

Random Sample of Residents: Two if the 20 interviewed residents were aware of outside services. The two residents believed they could privately talk to their lawyer and stated that the facility allows them to talk their parents or to someone else.

Residents who Reported a Sexual Abuse: Three of the four residents reported that if they wanted to talk to their lawyer, they would be allowed to have a private conversation. One resident was fixated on that they did not know who their attorney was therefore they don't know if they could talk to them. All four the interviewed residents reported that they could talk to their parents or someone else. When probed the residents' stated parents, family, and grandparents.

Corrective Action:
A majority of the youth were not aware of the rights to access outside victim advocates. The auditor recommended that the facility to the *Student Orientation* packet and add numbers for local or national victim advocate or rape crisis organization. While the facility had posted material, the above is recommendation to reiterate the process. The Student Orientation packet was updated to include the following:

Access to Victim Services

Students have the right to contact victim support services or an advocate following an allegation of abuse. Support services are available locally from Access Assault Care Center at 515-292-5378 or Toll Free 800-203-3488, the Blank Children's STAR Center at 515-241-4311, or the Child Abuse Hotline at 1-800-362-2178.

There is no further action recommended, the facility has met the requirements of the provision.

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

Corrective Action:
The following items are pending and will need to be provided in order to determine compliance:

- Recommendation: The youth are not aware of access for victim services or an advocate. One way to remedy this is to update the *Student Orientation* packet and add numbers for local or national victim advocate or rape crisis organization. While the facility had posted material, the above is recommendation to reiterate the process.

During the post audit phase, the facility updated its Student Orientation packet to provide telephone numbers and addresses for the outside entity that can provide advocacy and emotional supportive services. There is no further action recommended. The facility is in compliance with the standard.

Standard 115.354: Third-party reporting

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

115.354 (a)

- Has the agency established a method to receive third-party reports of sexual abuse and sexual harassment? ☒ Yes ☐ No

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Website

Findings (By Provision):
115.354 (a). As reported in the PAQ, the facility provides a method to receive third-party reports of resident sexual abuse or sexual harassment. The facility website contains information on how to conduct a third-party report at: PREA INFORMATION | Woodward Academy (wwacademy.com).

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

Corrective Action:
No corrective action is recommended for this standard.

OFFICIAL RESPONSE FOLLOWING A RESIDENT REPORT

Standard 115.361: Staff and agency reporting duties

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

115.361 (a)

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether or not it is part of the agency? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding retaliation against residents or staff who reported an incident of sexual abuse or sexual harassment? ☒ Yes ☐ No

- Does the agency require all staff to report immediately and according to agency policy any knowledge, suspicion, or information regarding any staff neglect or violation of responsibilities that may have contributed to an incident of sexual abuse or sexual harassment or retaliation? ☒ Yes ☐ No

115.361 (b)

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

115.361 (c)

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

115.361 (d)

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

- Are medical and mental health practitioners required to inform residents of their duty to report, and the limitations of confidentiality, at the initiation of services? ☒ Yes ☐ No

115.361 (e)

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

- Upon receiving any allegation of sexual abuse, does the facility head or his or her designee promptly report the allegation to the alleged victim's parents or legal guardians unless the facility has official documentation showing the parents or legal guardians should not be notified? ☒ Yes ☐ No

- If an alleged victim is under the guardianship of the child welfare system, does the facility head or his or her designee promptly report the allegation to the alleged victim's caseworker instead of the parents or legal guardians? ☒ Yes ☐ No

- If a juvenile court retains jurisdiction over the alleged victim, does the facility head or designee also report the allegation to the juvenile's attorney or other legal representative of record within 14 days of receiving the allegation? ☒ Yes ☐ No

115.361 (f)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Policy:
        i. Prison Rape Elimination Act "PREA"
        ii. Child Abuse
        iii. PREA Zero Tolerance
    b. Pre-Audit Questionnaire (PAQ)
    c. Iowa Code 232.69
    d. Magellan Health Services Members Rights and Responsibilities Statement
    e. Allegations of Sexual Abuse or Sexual Harassment
2. Interviews:
    a. Random sample of staff -12
    b. Medical and mental health staff - 2
    c. Executive Director
    d. PREA compliance manager

Findings (By Provision):

115.361 (a). As reported in the PAQ, the agency requires all staff to report immediately and according to agency policy any knowledge, suspicion, or information they receive regarding an incident of sexual abuse or sexual harassment that occurred in a facility, whether it is part of the agency. The Prison Rape Elimination Act "PREA" policy, requires that "sstaff must report immediately any knowledge, suspicion, or information that they receive regarding: an incident of sexual abuse or sexual harassment that occurred at Woodward Academy, retaliation against residents or staff that reported such an incident; and/or, any staff negligence or violation of responsibilities that may have contributed to an incident or retaliation" *(p. 7)*.

<u>Interviews</u>

Random Sample of Staff: Twelve staff interviews indicated a clear understanding of the duty to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility. Twelve staff was able to articulate that they were mandated reporter, and any knowledge or suspicion of incident would have to be reported immediately to supervisor. The staff understood 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 of retaliation immediately. The various ways staff indicated that they could make a report included, but was not limited to:

- Report to supervisor
- Report to the PREA Hotline
- Report to the coordinator
- Notify DHS
- Contact Local Law Enforcement

The 12 interviewed staff consistently described a process for reporting any information related to sexual abuse incidents as: report immediately, separate residents, close off the area of the incident, do not allow the resident to bath, shower, or brush teeth. Staff stated that supervisor, law enforcement or DHR would conduct investigation.

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

115.361 (b). As reported in the PAQ, the Woodward Academy facility requires that all staff comply with any applicable mandatory child abuse reporting laws. The Child Abuse policy provides guidance on Woodward Academy's responsibility to adhere to Iowa Department of Human Services' regulations regarding child abuse for the protection of the student's rights and overall well-being" *(p. 1)*.

Interviews

Random Sample pf Staff: Twelve interviewed staff, representing staff from all shifts, were interviewed. Interviews confirmed that each of the staff received PREA education during the initial job training. Interviews with staff indicated they are all aware of the Zero Tolerance Policy, employee and Resident rights, signs and symptoms of sexual abuse, reporting and responding. Twelve of the random staff reported being knowledgeable of the topics they had been trained in. The staff were able to describe the training on zero tolerance, Resident and staff rights, dynamics of sexual abuse and sexual harassment, prevention and response protocol as well supportive services available to residents. Five of the staff interviewed reported that they couldn't recall if they received training on how to effectively communicate and professionally with residents, including lesbian, gay, bisexual, transgender, intersex, or gender nonconforming residents.

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

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

Interviews

Random Sample pf Staff: Random Sample of Staff: Twelve staff interviews indicated a clear understanding of the duty to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility. Twelve staff was able to articulate that they were mandated reporter, and any knowledge or suspicion of incident would have to be reported immediately to supervisor. The staff understood 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 of retaliation immediately. The various ways staff indicated that they could make a report included, but was not limited to:

- Report to supervisor
- Report to the PREA Hotline
- Report to the coordinator

- Notify DHS
- Contact Local Law Enforcement

The 12 interviewed staff consistently described a process for reporting any information related to sexual abuse incidents as: report immediately, separate residents, close off the area of the incident, do not allow the resident to bath, shower, or brush teeth. Staff stated that supervisor, law enforcement or DHS would conduct investigation.

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

115.361 (d). Iowa Code 232.69 provides guidance on medical and mental health; along with all staff of a licensed facility is responsible for reporting child abuse. The client and parent sign a Magellan Health Services Members Rights and Responsibilities Statement which discloses the limitation of confidentiality in that the provider is required to report abuse and fraud.

Interviews

Medical and Mental Health Staff: The interviewed medical and mental health staff all reported that upon admission/intake residents are notified regarding the limitations of confidentiality and the staff duty to report. It was also reported that the parents sign a limitation of confidentiality form. All of the medical and mental health staff stated that they are required to report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment to a designated supervisor or official immediately upon learning of it. The interviewed staff reported that they had to make any reports at the Woodward Academy.

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

115.361 (e). The Prison Rape Elimination Act "PREA" policy states that the "Executive Director or designee must notify the DHS Bureau of Child Welfare funding and Juvenile Programs on the incident" (*p.* 8). The policy further states that the "executive director or designee also ensures that incidents of sexual assault/rape, findings of investigations, and other pertinent information is reported to the student's court of jurisdiction, the student's worker and the student's parent (s) or legal guardian" (*p. 8*).

Documentation Reviewed

Upon review of 12 allegations of sexual abuse or sexual harassment, there were no identified allegations that were directly reported to the medical or mental health staff.

Interviews

PREA Compliance Manager: The interviewed PCM reported that allegations of sexual abuse are reported to child protective services, law enforcement if it is believed that the situation is criminal, parents and workers are notified that their child is involved in an investigation; however, details are not provided. The guardian and the DHS worker are contacted within the next business day. The PCM reported that they do not notify attorneys.

Executive Director (ED): The interviewed director stated that when they receive an allegation of sexual abuse is reported to the PREA officer/Executive Director; child protective services, law enforcement, legal guardians, the worker as well as the Department of Inspections and Appeals. If the victim is under the guardianship of the child welfare system, the caseworker and whomever is legal guardians is contacted. Said reports are made within 24 hours, and if the youth is juvenile court involved, they would not contact the attorney however the student can contact the attorney.

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

115.361 (f). Policy *PREA Zero Tolerance* provides the following guidance on reporting sexual abuse or sexual harassment:

1. Staff must report immediately any knowledge, suspicion, or information that they receive regarding: an incident of sexual abuse or sexual harassment that occurred at the facility, retaliation against clients or staff that reported such an incident; and/or, any staff negligence or violation of responsibilities that may have contributed to an incident or retaliation.
2. Staff receiving a report of a sexual assault/rape or attempted sexual assault/rape, or staff that become aware of sexual activity between clients or between a client and a staff, contractor, visitor or volunteer must immediately report this event to the program director. The program director must immediately relay the report to the PREA Compliance Manager. The PREA Compliance Manager will notify the Group Living Director and Executive Director/Designee. The Executive Director or designee is responsible for notifying Licensure, any state entity notifications, and appropriate Administration.
3. The Executive Director or designee that is responsible for receiving a report of actual or suspected sexual abuse or rape must immediately (in conjunction with the process listed in F1) call the placing state CPS or DCS and report the incident and/or allegation. The staff receiving the report of actual or suspected sexual abuse or rape must submit an Incident Report before the end of their work shift and follow program protocol.

Documentation Reviewed

- The auditor reviewed 12 allegations of sexual abuse and/or sexual harassment. The facility followed the protocol in place of reporting allegations and assignment for investigation (internal/external).

Interviews
Executive Director (ED): The interviewed ED reported that all allegations of sexual abuse and sexual harassment are directly reported to the designated investigators.

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

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.362: Agency protection duties

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

115.362 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Policy:
        i. *Zero Tolerance*
    b. Pre-audit Questionnaire (PAQ)
2. Interviews:
    a. Agency head
    b. Executive Director
    c. Random sample of staff - 12

Findings (By Provision):
115.362 (a). As reported in the PAQ, there were zero instances during the past 12 months where the facility determined that a resident was subject to substantial risk of imminent sexual abuse. Additionally, there have been no instances in which the agency had to isolate a resident due to imminent danger of sexual abuse that required immediate action.

Policy & Procedures, *Zero Tolerance*, states that, "sstaff must report immediately any knowledge, suspicion, or information that they receive regarding: an incident of sexual abuse or sexual harassment that occurred at the facility, retaliation against residents or staff that reported such an incident; and/or, any staff negligence or violation of responsibilities that may have contributed to an incident or retaliation" *(p. 7)*. The policy further states that, "The Executive Director or designee must take immediate steps to protect the alleged victim from further potential sexual assault/rape (if still at the facility) by separating the alleged victim from the alleged perpetrator(s) including arranging for separate housing, dining, and/or other elements of daily routine to the extent necessary to ensure protection" *(p.*9).

<u>Interviews</u>
Agency Head: The interviewed agency head reported that the agency has granted facility leadership the autonomy to take any immediate action necessary to protect clients from imminent threats of abuse, so long as such action does not violate policy, law, or regulation. Immediate protective actions may include but are not limited to separating potential perpetrators and victims, enhancing staffing ratios, providing clinical support to the potential perpetrator or victim, contacting law enforcement if necessary, and protecting evidence if necessary.

It is the agency's expectation that if a client is at imminent risk of sexual abuse, staff are to cease all other priorities and immediately ensure protection of the potential victim before assuming any other responsibilities or tasks.

Executive Director (ED): The ED reported that once they are made aware that a resident is subject to a substantial risk of imminent sexual abuse, they will remove the student from the dorm if possible, the

student will be on close observation, appropriate supervisors will be made aware of the situation for monitoring and safety, and a safety plan will be developed and communicated with the student regarding his/her rights, numbers to call, safe words, etc. It is expected that staff should respond immediately as well as communicating to chain of command all the way up to the Quality and Compliance officer and Executive Director.

Random Sample of Staff: The 12 interviewed staff consistently described a process for reporting any information related to sexual abuse incidents as: report immediately, separate residents, close off the area of the incident, do not allow the resident to bath, shower, or brush teeth.

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

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.363: Reporting to other confinement facilities

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

115.363 (a)

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

115.363 (b)

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

115.363 (c)

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

115.363 (d)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Policy:
        i. Prison Rape Elimination Act "PREA"
    b. Pre-Audit Questionnaire (PAQ)
2. Interviews:
    a. Agency head
    b. Executive Director

115.363 (a). As reported in the PAQ, the agency has a policy requiring that, upon receiving an allegation that a resident was sexually abused while confined at another facility, the head of the facility must notify the head of the facility or appropriate office of the agency or facility where sexual abuse is alleged to have occurred. During the past 12 months, there were zero reported allegations of sexual abuse that the facility received from other facilities.

The Prison Rape Elimination Act "PREA" policy states that "if a report is received of sexual abuse from another agency, the Executive Director must report Director-to-Director to the other facility within 72 hours" *(p. 2)*.

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

115.363 (b). The Woodward Academy facility policy requires that the facility head provides such notification as soon as possible, but no later than 72 hours after receiving the allegation. Per the PAQ, there were no allegations of sexual abuse received at Woodward Academy which required notification to another facility head. Additionally, there were no reported allegations of sexual abuse received at another facility who which notification was received at Woodward Academy during the reporting period.

The Prison Rape Elimination Act "PREA" policy states that "if a report is received of sexual abuse from another agency, the Executive Director must report Director-to-Director to the other facility within 72 hours" *(p. 2)*.

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

115.363 (c). Per the PAQ, there were no allegations of sexual abuse received at Woodward Academy which required notification to another facility head. Additionally, there were no reported allegations of sexual abuse received at another facility who which notification was received at Woodward Academy during the reporting period. Based upon review of documentation the facility met the requirements of the provision.

115.363(d). As reported in the PAQ, the agency or facility requires that all allegations received from other agencies or facilities are investigated in accordance with the PREA standards. The Prison Rape Elimination Act "PREA" policy states that "if a report is received of sexual abuse from another agency, the Executive Director must report Director-to-Director to the other facility within 72 hours" *(p. 2)*.

There were no reported incidents of allegations within the last 12 months from other facilities.

Interviews

Agency Head: The interviewed agency head reported that the agency requires that all PREA certified facilities have a designated PREA Compliance Manager (PCM). This PCM shall serve as the designated point of contact for all reports of sexual abuse or harassment alleged to have been perpetrated against clients. Upon receipt of an allegation, the PCM shall ensure the facility head, agency leadership, and external authorities are notified and that an external or administrative investigation occurs in compliance with company policy, law, and regulation. There have been no examples of such allegations from 10/1/21 to the date of this interview.

Executive Director (ED): The interviewed ED reported that when the facility receives an allegation from another facility or agency that an incident of sexual abuse or sexual harassment occurred in their facility, they would report the same was as if the allegation were coming from the campus. The ED is aware of two examples of where that occurred.

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

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.364: Staff first responder duties

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

115.364 (a)

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

- Upon learning of an allegation that a resident was sexually abused, is the first security staff member to respond to the report required to: Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence? ☒ Yes ☐ No

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

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

115.364 (b)

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

Auditor Overall Compliance Determination

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
   a. Pre-Audit Questionnaire (PAQ)
   b. Policy:
      a. Prison Rape Elimination Act "PREA"
      b. PREA Zero Tolerance
   c. PREA Training
   d. Training Log/Record
   e. PREA Allegations/Incidents
2. Interviews:
   a. Security and non-security staff first responders -13
   b. Random sample of staff – 12
   c. Resident who reported sexual abuse - 4

Findings by Provision:

115.364 (a). As reported in the PAQ, the agency has a first responder policy for allegations of sexual abuse. Upon learning of an allegation that a resident was sexually abused, the first security staff member to respond to the report shall be required to:

- Separate the alleged victim and abuser.
- Preserve and protect any crime scene until appropriate steps can be taken to collect any evidence.
- If the abuse occurred within a time period that still allows for the collection of physical evidence, 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/or.
- 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.*

The Prison Rape Elimination Act "PREA" policy provides guidance on the above first responder duties.

As reported in the PAQ, there was ten allegations of sexual abuse reported in the last 12 months. Of those allegations, there were zero times in which first security staff members served as first responders.

<u>Documentation Reviewed</u>

- The auditor reviewed 11 allegations of sexual abuse and/or sexual harassment that occurred in the last 12 months at the facility.
- One sexual abuse (consensual) incident reviewed in the post audit phase.

Interviews

Security Staff and Non-Security Staff First Responders: Security Staff and Non-Security Staff First Responders/Random Sample of Staff: Twelve random staff interviewed consistently reported that the duties of a first responder to include, but are not limited to: take immediate action, stay with the resident, separate the victim from the perpetrator, isolate/secure the scene and secure evidence, call for additional staff, notify supervisor, and contact law enforcement. When asked who you would not share the information with and staff stated other residents, and/or unnecessary staff.

Residents who Reported a Sexual abuse: Four residents were interviewed who reported sexual abuse while at Woodward Academy. One of the four residents reported that staff responded within a day. One resident stated after they told staff, staff did nothing. All of the residents stated that they told staff about the abuse. The residents reported that after staff was informed, they moved the other youth. Two of the residents stated that staff spoke to them about the incident and safety protocols were put in place. One resident said three weeks later he was given a paper to sign saying he was notified of the results of the incident.

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

115.364 (b). As reported in the PAQ, the policy requires that if the first staff responder is not a security staff member, that responder shall be required to:

- Request that the alleged victim not take any actions that could destroy physical evidence; and/or
- Notify security staff.

The Prison Rape Elimination Act "PREA" and *PREA Zero Tolerance* policy provides guidance on the above first responder duties.

Documentation Reviewed

- Upon review of the training curriculum, staff are provided training on their first responder duties.
- The auditor reviewed the training records of 20 staff who were trained in the last year.
- Completion of updated training (139)

Interviews

Security Staff and Non-Security Staff First Responders/Random Sample of Staff: Twelve random staff interviewed consistently reported that the duties of a first responder to include, but are not limited to: take immediate action, stay with the resident, separate the victim from the perpetrator, isolate/secure the scene and secure evidence, call for additional staff, notify supervisor, and contact law enforcement. When asked who you would not share the information with and staff stated other residents, and/or unnecessary staff.

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

Corrective Action:

No corrective action is recommended for this standard.

Standard 115.365: Coordinated response

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

115.365 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Policy:
        i. Prison Rape Elimination Act "PREA"
    b. Pre-Audit Questionnaire (PAQ)

2. Interviews:
    a. Executive Director

Findings (By Provision):

115.365 (a). As reported in the PAQ, the facility developed a written institutional plan to coordinate actions taken in response to an incident of sexual abuse. The Woodward Academy facility has a written institutional plan to coordinate actions taken in response to an incident of sexual abuse among staff first responders, medical and mental health practitioners, investigators, and facility leadership. The PREA compliance manager is responsible for the oversight of the said plan. In part, the plan (Prison Rape Elimination Act "PREA") states that the reporting duties are as follows:

- The victim and alleged perpetrator must be separated and be kept separated from each other and prevented from communicating.
- Reporting must occur as listed in Section F.
- If the assault is alleged to have occurred within the past 96 hours, the victim must be transported to Dallas County Emergency Room (or alternate if directed by Administration or emergency personnel" for examination by qualified personnel. If the assault is alleged to have occurred more than 96 hours earlier, the hospital is contacted for instructions.
- Qualified investigators must take victim statements, open an investigation, and if applicable collect physical evidence.
- The area where the suspected assault took place is sealed off until investigators can gather evidence. Note: staff or medical personnel can enter the area if it is necessary to ensure student

safety, for example if a student needed medical attention or first aid before being transported, but efforts must be made to disturb the area as little as possible.
- Any clothing or articles belonging to the victim are left in place and not handled or disturbed until investigators have gathered evidence. The victim must not be allowed to shower or change clothing before being transported to the hospital.
- Staff must not extensively interview victims or alleged perpetrators for incident details beyond obtaining the basic information necessary so that decisions regarding further actions may be made, such as separation of victims and perpetrators, facilitating for victim medical needs, etc.
- Staff must submit an Incident Report before the end of their shift. Incident Reports must contain all facts as known, including the victim's statement of allegation in the victim's own words. Reports must not express the writer's opinion.
- Staff must not discuss the details of sexual abuse allegations or incidents beyond the extent needed to maintain safety and security at the facility, with persons other than Supervision/Management, investigators, and prosecuting officials (*pp. 10-11*).

Interviews

Executive Director (ED): When interviewing the ED, the process was further confirmed in that facility will follow the protocol identified in the institutional response plan. The ED further elaborated that staff first responders:

- Will have one point of contact to coordinate. This will be the ED, Group Living Director or Compliance Director.
- Make sure all parties follow the following protocol:
  - Separate victim and perpetrator-zero communications
  - Call supervisor
  - Preserve and protect the scene
  - If abuse occurred within a time period that still allows for the collection of physical evidence, request the alleged victim not take any actions that could destroy physical evidence i.e., washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating.
  - If abuse occurred within a time period that still allows for the collection of physical evidence, request the alleged abuser not take any actions that could destroy physical evidence i.e., washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating.
  - Incident report written I the resident's own words-turned in before end of shift to supervisor/PREA coordinator to review-do not extensively interview resident-i.e., do not follow through with the 5Ws.
  - Complete a DHS-3200 (Report of Actual or Suspected Child Abuse or Neglect) and class in mandatory report-24-hour verbal and 48 hours written-mandatory reporter.

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

Corrective Action:
No corrective action is recommended for this standard.

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

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

115.366 (a)

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

115.366 (b)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

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

Findings (By Provision):

115.366 (a). As reported in the PAQ, the Woodward Academy facility does not have collective bargaining. This section is not applicable. The facility, thereby, materially meets the provision for this standard.

Documentation Reviewed

A memo was provided, dated 2/16/2022, indicating that the facility has never been involved in a collective bargaining agreement.

Interviews

Agency Head: The agency head further confirmed that the facility does not engage in collective bargaining.

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

Corrective Action:

The following items are pending and will need to be provided in order to determine compliance:

- Write a memo that states there was no collective bargaining.

During the post audit phase, a memo was provided supporting the response to the provision. There are no further actions recommended. The facility is in compliance with the standard.

Standard 115.367: Agency protection against retaliation

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

115.367 (a)

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

- Has the agency designated which staff members or departments are charged with monitoring retaliation? ☒ Yes ☐ No

115.367 (b)

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

115.367 (c)

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: The conduct and treatment of residents or staff who reported the sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: The conduct and treatment of residents who were reported to have suffered sexual abuse to see if there are changes that may suggest possible retaliation by residents or staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency: Act promptly to remedy any such retaliation? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Any resident disciplinary reports? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Resident housing changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Resident facility changes? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Negative performance reviews of staff? ☒ Yes ☐ No

- Except in instances where the agency determines that a report of sexual abuse is unfounded, for at least 90 days following a report of sexual abuse, does the agency monitor: Reassignments of staff? ☒ Yes ☐ No

- Does the agency continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need? ☒ Yes ☐ No

115.367 (d)

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

115.367 (e)

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

115.367 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        i. Prison Rape Elimination Act "PREA"

c. *PREA Retaliation Monitoring Log* (1)
d. *Post Audit Allegation (2 Monitoring forms completed)*

2. Interviews:
   a. Agency head
   b. Executive Director
   c. Designated staff member charged with monitoring retaliation – 1
   d. Residents who reported a sexual abuse - 4

Findings (By Provision):

115.367 (a). As reported in the PAQ, the facility has a policy to protect all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents or staff. The Prison Rape Elimination Act "PREA" policy, *(p. 9)*, establishes protective measures for all residents and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigations from retaliation by other residents and staff.

There was one allegation of sexual abuse that was monitored for retaliation. The monitoring occurred over a six-week time frame, up until the conclusion of the investigation. During the post audit phase, the auditor reviewed the monitoring that occurred for an allegation of sexual abuse. The allegation was unfounded therefore monitoring ended.

Documentation Reviewed
Monitoring for Retaliation

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

115.367 (b). As previously described, the Woodward Academy the Prison Rape Elimination Act "PREA" policy states that, the Executive Director or designee must take immediate steps to protect the alleged victim from further potential sexual assault/rape (if still at the facility) by separating the alleged victim from the alleged perpetrator (s) including arranging for separate housing, dining, and/or other elements of daily routine to the extent necessary to ensure protection" (*p. 9*).

During the post audit phase, the auditor reviewed the monitoring that occurred for an allegation of sexual abuse. The allegation was unfounded therefore monitoring ended.

Documentation Reviewed
Monitoring for Retaliation

Interviews
Agency Head: The interviewed agency head reported that it is the policy of the agency that no person who makes a good faith report of an alleged violation of company policy, law, or regulation (including allegations of sexual abuse or harassment), or who cooperates with an investigation of such, be subject to retaliation. In the event of an allegation of sexual abuse or harassment at a PREA certified facility, the facility PCM shall develop a retaliation protection plan (including a monitoring period [i.e., 90 days]) with the client's care team or staff's human resource or supervision team. This plan may include, but is not limited to, increased data monitoring, removing the alleged perpetrator from contact with the alleged victim, unit reassignments, staffing ratio changes, or scheduling changes. It is the responsibility of the PCM and facility head to ensure that the reporter is adequately monitored and interviewed to ensure they are not experiencing retaliation until the end of the monitoring period.

Executive Director: The interviewed ED reported that the following steps are taken to protect residents from staff retaliation:

- Separate victim and perpetrator-zero communications
- Call supervisor
- Preserve and protect the scene
- If abuse occurred within a time period that still allows for the collection of physical evidence, request the alleged victim not take any actions that could destroy physical evidence i.e., washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating.
- If abuse occurred within a time period that still allows for the collection of physical evidence, request the alleged abuser not take any actions that could destroy physical evidence i.e., washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking or eating.
- Incident report written l the resident's own words-turned in before end of shift to supervisor/PREA coordinator to review-do not extensively interview resident-i.e., do not follow through with the 5Ws.
- Complete a DHS-3200 (Report of Actual or Suspected Child Abuse or Neglect) and class in mandatory report-24-hour verbal and 48 hours written-mandatory reporter.

Designated Staff Charged with Monitoring for Retaliation: The interviewed staff that is designated to monitor for retaliation reported that they would be responsible for monitoring the youth. The compliance manager would conduct the monitoring. The compliance manager reported that they would explain to the youth that they did the right thing, and that they are not in trouble. It was further stated that they would follow up with the students to explain the results of the investigation and give them a chance to share anything with them. The compliance manager would monitor grievances, so if a staff or student felt they were retaliated against they could file a grievance and would assist them if necessary.

The different measures that would be taken include but are not limited to make it clear to the dorm supervisor that nothing can be done that could be misconstrued as retaliation. For example, moving an alleged victim to another dorm instead of the alleged perpetrator. As the monitor, it would be encouraged by staff and students involved in abuse reports to contact a supervisor or the compliance manager if they have any questions or concerns. Monitor would begin as soon as the abuse is reported. The compliance manager reported that they would also follow up with the resident when the investigation is concluded.

Residents who Reported a Sexual Abuse: Four residents were interviewed who reported a sexual abuse. Two of the four residents stated that they feel safe and protected. One resident stated that he feels other residents want revenge and one resident stated that other kids look at his butt. One resident reported that the staff are very supportive.

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

115.367 (c). As reported in the PAQ, the facility monitors for retaliation for 90 days, and will continuing monitoring past 90 days if needed. There were zero reported incidents of retaliation reported in the last 12 months.

The Prison Rape Elimination Act "PREA" policy states that "the conduct and treatment of students or staff that report an abuse incident or are cooperating witnesses, will be monitored by mid or upper-level management for at least 90 days: (*p. 9*). The facility provided a sample of the *PREA Retaliation Monitoring Log* to show how monitoring will be documented.
During the post audit phase, the auditor reviewed the monitoring that occurred for an allegation of sexual abuse. The allegation was unfounded therefore monitoring ended.

Documentation Reviewed
Monitoring for Retaliation

Interviews
Executive Director (ED): The interviewed ED reported that the following measures are in place if retaliation is suspected:

- Designate staff member charged with monitoring retaliation.
- Supervisors notified and made clear of zero retaliation.
- Safety plan put in lace if we suspect retaliation such movement of dorms, discipline of staff, etc.
- Notification of all parties.
- This will be monitored for 90 days and reevaluated unless the student leaves.

Designated Staff Charged with Monitoring for Retaliation: The designated staff who monitor for retaliation stated that, they facility would monitor disciplinary reports, housing or program changes, or negative performance reviews or reassignment of staff. At the time of the onsite audit the facility did not have a monitoring time frame in place and reported that it is something that they need to implement. The compliance manager reported that they are no aware that the monitoring should occur during a 90-day time frame unless the allegation is deemed unfounded.

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

115.367 (d). The Prison Rape Elimination Act "PREA" policy, states that, **"**monitoring will include periodic status checks and disciplinary reports" (*p. 9*). During the post audit phase, the auditor reviewed the monitoring that occurred for an allegation of sexual abuse. The allegation was unfounded therefore monitoring ended.

Documentation Reviewed
Monitoring for Retaliation

Interviews
Designated Staff Charged with Monitoring for Retaliation: The interviewed staff reported that they are aware of any dorm changes with students involved in an abuse report. The staff designated to monitor for retaliation attends several meetings each week where major campus concerns are documented.

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

115.367 (e). The Prison Rape Elimination Act "PREA" policy, states that "monitoring of other individual who cooperates with an investigation who expresses fear of retaliation, the agency shall take appropriate measures to protect the individual against retaliation" *(p. 2)*.

Interviews
Agency Head: The interviewed agency head reported that all allegations of retaliation are taken seriously and reported for investigation. Allegations of retaliation on the part of staff may be escalated to investigation by a member of the agency's Human Resources or Compliance teams. Alleged victims of retaliation may be interviewed for input on a safety plan and may be provided resources from an external advocate (for clients) or the employee assistance program (for staff).

Executive Director (ED): The interviewed ED reported that for allegations of sexual abuse or sexual harassment, the different measures that would be taken to protect residents and staff from retaliation include:

- Separate the victim and perpetrator-zero communication
- Call supervisor
- Preserve and protect the scene
- If abuse occurred within a time period that still allows for the collection of physical evidence, request the alleged victim and abuser not take any action that could destroy the physical evidence…i.e., Washing, brushing teeth, changing cloths, urinating, defecating, smoking, drinking, or eating.
- Complete an incident report
- Complete a DHS 3200 report of actual or suspected child abuse or neglect

It was further reported that a designated staff member would be responsible for monitoring. Supervisors are notified and made clear of zero retaliation. A safety plan would be put in place. Appropriate parties would be notified, and the monitoring would occur for 90 days and reevaluated unless the resident leaves.

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

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

Corrective Action:
The following items are pending and will need to be provided in order to determine compliance:

- Provide a copy of the monitoring retaliation that occurred on all allegations of sexual abuse. If monitoring didn't occur, we will have to have a corrective action for a period of time. If there have been any new allegations since I was onsite, please ensure that monitoring occurs.

In corrective action, the facility was able to show how monitoring would occur. Prior to the corrective action phase, the facility kept a log but did not have a document to show how monitoring was done. During the corrective action phase, the facility completed monitoring on an allegation of sexual abuse. There is no further action recommended for the standard.

Standard 115.368: Post-allegation protective custody

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

115.368 (a)

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

Auditor Overall Compliance Determination

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

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

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

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

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        i. Prison Rape Elimination Act "PREA"
    c. Investigation-12 (one post onsite audit)
2. Interviews:
    a. Executive Director
    b. Staff who supervise residents in isolation
    c. Medical and mental health staff - 2

Findings (By Provision):

115.368 (a). As reported in the PAQ, the facility does not have a policy that residents who allege to have suffered sexual abuse may only be placed in isolation as a last resort if less restrictive measures are inadequate to keep them and other residents safe, and only until an alternative means of keeping all resident's safe can be arranged. The facility does not use any form of isolation. Policy *Prison Rape Elimination Act "PREA*", provides guidance on the agency use of alternative housing placement of victims and perpetrators. While isolation is not used, there immediate steps that can be taken to protect the alleged victim from further potential sexual assault/rape.

Interviews

Executive Director (ED): The interviewed ED reported that the facility does not utilize isolation. The students would be separated until an appropriate safety plan is developed.

Medical and Mental Health Staff: The interviewed mental health and medical staff reported that isolation is not utilized at the facility; and the youth would receive ongoing care to include but not limited to close observation and ongoing medical and mental health services.

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

Corrective Action:

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

INVESTIGATIONS

Standard 115.371: Criminal and administrative agency investigations

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

115.371 (a)

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

- Does the agency conduct such investigations for all allegations, including third party and anonymous reports? [N/A if the agency/facility is not responsible for conducting any form of criminal OR administrative sexual abuse investigations. See 115.321(a).]
  ☒ Yes ☐ No ☐ NA

115.371 (b)

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

115.371 (c)

- Do investigators gather and preserve direct and circumstantial evidence, including any available physical and DNA evidence and any available electronic monitoring data? ☒ Yes ☐ No

- Do investigators interview alleged victims, suspected perpetrators, and witnesses?
  ☒ Yes ☐ No

- Do investigators review prior reports and complaints of sexual abuse involving the suspected perpetrator? ☒ Yes ☐ No

115.371 (d)

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

115.371 (e)

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

115.371 (f)

- Do agency investigators assess the credibility of an alleged victim, suspect, or witness on an individual basis and not on the basis of that individual's status as resident or staff?
  ☒ Yes ☐ No

- Does the agency investigate allegations of sexual abuse without requiring a resident who alleges sexual abuse to submit to a polygraph examination or other truth-telling device as a condition for proceeding? ☒ Yes ☐ No

115.371 (g)

- Do administrative investigations include an effort to determine whether staff actions or failures to act contributed to the abuse? ☒ Yes ☐ No

- Are administrative investigations documented in written reports that include a description of the physical evidence and testimonial evidence, the reasoning behind credibility assessments, and investigative facts and findings? ☒ Yes ☐ No

115.371 (h)

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

115.371 (i)

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

115.371 (j)

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

115.371 (k)

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

115.371 (l)

- Auditor is not required to audit this provision.

115.371 (m)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        i. Prison Rape Elimination Act "PREA"
        ii. Referrals for Internal and External Investigations
        iii. *PREA Evidence Protocol Forensic Medical Examinations*
    c. Investigations-12 (One post onsite audit)
    d. Specialized Training for Investigators
2. Interviews:
    a. Executive Director
    b. PREA coordinator
    c. PREA compliance manager
    d. Investigator -2
    e. Resident who reported sexual abuse - 4

Findings (By Provision):

115.371 (a). As reported in the PAQ, the facility has a policy related to the investigation protocols. The *Prison Rape Elimination Act "PREA"* policy states that "each incident of alleged or reported sexual abuse or sexual assault/rape must be investigated to the fullest extent possible" (*p. 9*).

The auditor reviewed 12 allegations of sexual abuse or sexual harassment that occurred in the last 12 months. Based upon review it appears that the facility conducts an administrative investigation, while simultaneously allegations are referred to DHS and local law enforcement. Most of the investigative report consisted of the allegations, statements, and an investigation summary; however, it appears that allegations that occurred in 2020 did not have all of the required documents to thoroughly review the accuracy and requirements of the allegation. The initial allegation was investigated promptly, thoroughly and objectively.

An allegation that occurred in the post onsite phase, was properly investigated, showing the facilities ability to investigate allegations of sexual abuse and sexual harassment.

<u>Documentation Reviewed</u>

Investigations/Incident Report

<u>Interviews</u>

Investigative Staff: The interviewed investigative staff reported that as soon as it is known and reported to the compliance department/management team, the investigation begins. At that time, individuals are interviewed. It was also reported that anonymous reports would be handled in the same manner. For third party, they are investigated no differently than other abuse reports, aside from making sure there is no retaliation toward the reporter.

115.371 (b). Per the PAQ, the Woodward Academy facility reported having zero staff who were trained investigators. Upon further review it was identified that the facility PCM conducts the initial investigation. All allegations are also referred to local law enforcement and DHS however some findings are determined by the facility staff. The auditor notified the facility that the in-house investigator is required to complete a specialized training for investigation allegations of sexual abuse.

Documentation Reviewed
Specialized Training for Investigators Certificate

Interviews
Investigative Staff: The interviewed investigators reported that they were not trained on the above-mentioned topics. One investigator reported that they received training on how to preserve the crime scene and one investigator reported that they received training on how to establish questions to gain the facts that you are looking for.

Based on review of documents and interviews, it was identified that the facility did not have any investigators trained on conducting sexual abuse investigations. It is the auditor's recommendation that both investigators complete the specialized training hosted by the National Institute of Corrections (NIC).

During the post onsite audit phase, the facility had two staff complete the required specialized training for investigators.

115.371 (c). The *Prison Rape Elimination Act "PREA"* policy states that "qualified investigators must take victim statements, open an investigation, and if applicable collect physical evidence" *(p.2).*

Twelve allegations of sexual abuse were reviewed. There was one allegation that involved alleged anal penetration, it was difficult to determine if evidence was collected; however, there was evidence in all allegations that camera footage was reviewed. Based on review, the allegations that occurred in 2020 had minimal information provided to determine how evidence was handlined. Involved parties were interviewed and the interviews were documented.

An allegation that occurred in the post onsite phase, was properly investigated, showing the facilities ability to investigate allegations of sexual abuse and sexual harassment.

Documentation Reviewed
Investigation/Incident

Interviews
Investigative Staff: The interviewed investigative staff reported that the initial step is to separate the victim from the perpetrator, and to begin gathering facts. At that time, initial statements would be taken to determine if it needs referred to DHS or law enforcement. The investigation process includes meeting with the involved parties and conducting fact finding interviews and gather general information (who, what, when, where, why, etc.). If the case is alleged to be abuse, criminal, etc. it is referred to outside authorities. The investigators reported that they would not gather any evidence, only preserve it.

115.371 (d). As reported in the PAQ the facility does not terminate an investigation solely because the source of the allegation recants the allegation. Policy & Procedures, *Referrals for Investigations*, states that,

> The facility will not terminate an internal investigation based solely on the allegation being recanted, or employment being terminated. If during the course of an internal investigation, criminal activity is established, the Executive Director will immediately contact local authorities for further investigation. The facility will cooperate with any investigation conducted by an outside authority. Upon completion of an external investigation, Woodward Academy will request the findings from the appropriate agency in order to inform the resident. *(p. 2).*

Based on review of 11 allegations of sexual abuse or sexual harassment, it appears that no allegation was terminated solely because the source of the allegation recants the allegation. An allegation that

occurred in the post onsite phase, was properly investigated, showing the facilities ability to investigate allegations of sexual abuse and sexual harassment.

Documentation Reviewed
Investigation/Incident

Interviews
Investigative Staff: The interviewed investigators reported that an investigation would not necessarily terminate if the source recanted the allegation. It would depend on the nature of what was recanted but we would still follow the formal process. The residents have changed statements before, and our role isn't necessary to find guilt or innocence but to get the information to the right people.

115.371 (e). Policy & Procedures, *PREA Evidence Protocol Forensic Medical Examinations*, states that, "the facility will not conduct a criminal investigation, the Law Enforcement Entity will be responsible for criminal sexual abuse investigations. The facility will contact the Law Enforcement in the event of abuse. The facility or Law Enforcement Entity will investigate all allegations of sexual abuse and will follow a uniform evidence protocol that maximizes the potential for obtaining usable physical evidence for administrative proceedings and criminal prosecutions" *(p.1).*

The facility investigator conducts the initial inquiry into the allegation. Based on review of 11 allegations it appears that all allegations are referred to local law enforcement and local DHS for investigation. This process is consistently done on all allegations.

Interviews
Investigative Staff: The interviewed investigators reported that once it is believed that a crime has occurred, the case would be turned over to local law enforcement and CPS.

115.371 (f). Policy & Procedures, *Referrals for Investigations*, RR-PREA.322, states that, "Credibility of said victim(s), perpetrator(s) and witnesses shall be assessed on an individual basis and shall not be determined by the person's status as resident or staff. Investigators will review prior complaints and reports of sexual abuse involving the suspected perpetrator" *(p. 2).* Additionally, the policy states that, "the facility will not require a student who alleges sexual abuse to submit to a polygraph examination or any other truth telling devices as a condition for proceeding with the investigation of such an allegation" *(p. 2)*.

Eleven residents that reported sexual abuse were not required to take a polygraph test about what happened.

Interviews
Investigative Staff: One interviewed investigator reported that credibility is judged on an individual basis; however, all allegations are taken seriously. The other interviewed investigator reported that they are not in a position to judge credibility. They will take a statement and pass along the information. Both interviewed investigators reported that no one would be required to take a polygraph test.

Residents who Reported a Sexual Abuse: Four residents who reported a sexual abuse was interviewed. All of the residents reported that they were not required to take a polygraph test related to the incident. However, one resident reported that polygraph tests are a part of the sex offender treatment program.

115.371 (g). Policy & Procedures, *Referrals for Investigations*, indicates that:

> Documentation of evidence gathered, interviews conducted and any other activity pertaining to the allegation, including determination discussed with the accused, will be administered and

formulated into a report by the PREA Compliance Manager and will include facts and findings of the allegation. The facility shall make an administrative determination based on the preponderance of evidence gathered during the course of the investigation. This documentation will be retained for as long as the alleged abuser is a resident or employee of Woodward Academy, plus five years, unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention (*p.2*).

All investigations are detailed in a written report; to include the interview notes. There were 11 allegations of sexual abuse that occurred during the last 12 months. The allegations had a summary of findings and an investigative report. The allegations that occurred in 2020 had very limited information; however, upon further review it appears that an agency PREA compliance manager changed, and a more detailed analysis of an allegation was provided. An allegation that occurred in the post onsite phase, was properly investigated, showing the facilities ability to investigate allegations of sexual abuse and sexual harassment.

Documentation Reviewed

Investigation/Incident

Interviews
Investigative Staff: The interviewed investigators reported that they would involve human resources at times if we believed staff fault is the issue. If staff were at fault, we would follow policies to provide corrective action. It was also reported that they would make sure that ratio was correct, and review camera footage to determine if proper supervision was taken place. They would also interview staff who were present when the alleged abuse occurred. Statements are gathered from all interviews, facts gathered from video review.

115.371 (h). The facility does not conduct criminal investigations; however, the outcomes of such investigations are provided by Macon County Department of Human Resources or local law enforcement. Policy *PREA Referrals for Investigations* further supported that PREA Investigations indicates that all investigations shall be documented.

There were 11 allegations of sexual abuse that occurred during the last 12 months. The allegations had an administrative investigation along with referral to outside law enforcement and DHS. The investigative report consisted of the allegations, statements, and an investigation summary. An allegation that occurred in the post onsite phase, was properly investigated, showing the facilities ability to investigate allegations of sexual abuse and sexual harassment.

Documentation Reviewed

Investigation/Incident

Interviews
Investigative Staff: The interviewed investigators reported that they do not investigate criminal cases, however they would document as any other case, as well as any information gathered from camera reviews.

115.371 (i). Allegations of sexual abuse or sexual harassment that are criminal in nature are referred to local law enforcement. There were no substantiated allegations of sexual abuse.

Documentation Reviewed
Investigations/Incident

Interviews

Investigative Staff: The interviewed investigators reported that if it is criminal in nature it is referred to outside law enforcement. One of the interviewed investigators reported that they would lean towards overreporting to law enforcement as they are trained professionals.

115.371 (j). As reported in the PAQ the agency retains all written reports pertaining to administrative or criminal investigation of alleged sexual abuse or sexual harassment for as long as the alleged abuser is incarcerated or employed by the agency, plus five years. Policy & Procedures, *PREA Referrals for Investigations*, states that, "documentation will be retained for as long as the alleged abuser is a resident or employee of the facility, plus five years, unless the abuse was committed by a juvenile resident and applicable law requires a shorter period of retention.

The were 11 allegations of sexual abuse that occurred in the last 12 months. The auditor was able to review all of the allegations. It was identified that all of the required documents were not available on allegations that occurred in 2020. An allegation that occurred in the post onsite phase, was properly investigated, showing the facilities ability to investigate allegations of sexual abuse and sexual harassment.

Documentation Reviewed
Investigation/Incident

115.371 (k). Policy & Procedures, *Referrals for Investigations*, states that, "the facility will not terminate an internal investigation based solely on the allegation being recanted, or employment being terminated. If during the course of an internal investigation, criminal activity is established, the Executive Director will immediately contact local authorities for further investigation. The facility will cooperate with any investigation conducted by an outside authority. Upon completion of an external investigation, the facility will request the findings from the appropriate agency in order to inform the resident" *(p. 2)*.

Upon review of 11 allegations of sexual abuse or sexual harassment, the auditor identified two allegations were the involved staff member quit or was terminated prior to the conclusion of the investigation. The investigation continued and was not terminated based on the alleged abuser or victim from employment.

Interviews
Investigative Staff: The interviewed investigators reported that the various was the case would be handled if a staff member alleged to have committed sexual abuse or sexual harassment terminates prior to a completed investigation is to continue as usual, and/or allow law enforcement to take over.

115.371 (l). N/A

115.371 (m). When an outside agency investigates sexual abuse, the facility shall cooperate with outside investigators and shall endeavor to remain informed about the progress of the investigation.

Interviews
Investigative Staff: The interviewed investigators reported that they would share the initial information with the outside law enforcement and set up the location for the interviews to be conducted.

PREA compliance manager: The interviewed PREA compliance manager reported that once it is reported to CPS, they typically do not get any updates until they receive a decision in the mail.

Executive Director: The interviewed ED, reported that they would maintain constant communication with workers and guardians.

PREA Coordinator: The interviewed PREA coordinator reported that the agency follows a standard operating protocol for cooperating with, and staying informed of, all external agency surveys, audits, and

investigations. This information is tracked in a secure software system, where investigation "tickets" are not closed until the outcome is confirmed, codified, and stored compliantly.

Corrective Action:

Upon review of the allegations of sexual abuse there were several areas of concern identified. At the time of the onsite audit, the facility did not have a staff member who had completed the required specialized investigator training. It was also determined that not all of the allegations contained all of the required documents to review the investigation. It appears that there was a change of practice at the facility and the allegations investigated in the last 6 months contained the required elements per policy for investigation. The allegations of sexual abuse are referred to local law enforcement, it is recommended that staff obtain a copy or response to whether local law enforcement will or has investigated. The auditor will monitor allegations of sexual abuse and response to investigate during the corrective action phase.

An allegation that occurred in the post onsite phase, was properly investigated, showing the facilities ability to investigate allegations of sexual abuse and sexual harassment.

Standard 115.372: Evidentiary standard for administrative investigations

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

115.372 (a)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        i. Prison Rape Elimination Act "PREA"
    c. Investigations-12 (one during the post onsite phase)
    d. Specialized Training for Investigators Cerficate-2
2. Interviews:

a. Investigative Staff - 2

Findings (By Provision):

115.372 (a). The facility reported in the PAQ, that the agency does not impose a standard of preponderance of the evidence or a lower standard of proof for determining whether allegations of sexual abuse or sexual harassment are substantiated. The Prison Rape Elimination Act "PREA" policy, states that "Woodward Academy shall impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated" *(p.11*).

In efforts to ensure that the administrative investigators are aware of their duty and responsibility that 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, the auditor recommended that the staff involved with the administrative portion of the investigation complete specialized training for investigators. During the post onsite audit phase, two staff completed the required training.

Upon review of 11 allegations of sexual abuse and/or sexual harassment, it appears that the agency followed the protocol of preponderance of the evidence in most cases. There was one allegation that involved possible anal sex. Based on the information presented it was undetermined if the victim was seen by a medical provider.

Interviews

Investigative Staff: The interviewed investigators reported that the standard of evidence required to substantiate allegations of sexual abuse or sexual harassment include, taking a statement. They would not substantiate an allegation unless there were witnesses to corroborate or if it occurred on camera. The substantiated allegations can also occur with outside investigators.

Corrective Action:

While most allegations of sexual abuse were investigated using the proper protocols the auditor recommends that the necessary facility staff completed the specialized training for investigators to understand the scope of preponderance of evidence and how to properly handle evidence. During the post onsite audit phase, two staff completed the required training. An allegation that occurred in the post onsite phase, was properly investigated, showing the facilities ability to investigate allegations of sexual abuse and sexual harassment. Additionally, two facility staff completed the requested training to show compliance with the standard. No further action is needed at this time.

Standard 115.373: Reporting to residents

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

115.373 (a)

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

115.373 (b)

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

115.373 (c)

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer posted within the resident's unit? ☒ Yes ☐ No

- Following a resident's allegation that a staff member has committed sexual abuse against the resident, unless the agency has determined that the allegation is unfounded, or unless the resident has been released from custody, does the agency subsequently inform the resident whenever: The staff member is no longer employed at the facility? ☒ Yes ☐ No

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

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

115.373 (d)

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

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

115.373 (e)

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

115.373 (f)

- Auditor is not required to audit this provision.

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        i. Prison Rape Elimination Act "PREA"
    c. Investigation Report-12 (one unfounded)
    d. Notifications Reviewed 11
2. Interviews:
    a. Executive Director
    b. Investigative Staff - 2

Findings (By Provision):

115.373 (a). As reported in the PAQ, the facility does not have a policy requiring that any resident who makes an allegation that he or she suffered sexual abuse in an agency facility is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation by the agency. However, upon review of the *Prison Rape Elimination Act "PREA"* policy, the following procedures are in place:

1. Following an investigation into a resident's allegation of sexual abuse suffered at Woodward Academy, the agency shall inform the resident as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.

The PAQ indicated that there were 11 criminal or administrative PREA related incidents in the last 12 months:

1. The number of criminal and/or administrative investigations of alleged resident sexual abuse that was completed by the agency/facility/outside entity: 11 (2 unfounded)
3. Of the investigations that were completed of alleged sexual abuse, the number of residents that were notified, verbally or in writing, of the results of the investigation: 3; upon further review there were 5 notifications made.

Documentation Reviewed

Investigation Files-11

Interviews

Investigative Staff: The interviewed investigators reported that they will notify students of the findings of the allegation of sexual abuse.

Executive Director: The interviewed ED reported that the facility does not notify residents of allegations of sexual abuse. Upon further review and clarification notification is given to residents.

Corrective Action

Upon review of the investigative reports, it was identified that the facility did not consistently notify residents who alleged sexual abuse of the findings of the investigation. The facility will implement a corrective action and in order to determine compliance with the standard the facility shall provide a proof of notification during the corrective action phase for any allegations of sexual abuse.

During the post audit phase, the facility provided documentation of 11 notification reports. On one of the forms, it was noted that the resident was already discharged from the facility. In addition, the facility provided documentation of two notifications that occurred during the post onsite audit phase.

115.373 (b). The Woodward Academy facility utilizes an outside entity to conduct the criminal investigations. As reported in the PAQ, there were five investigations of alleged resident sexual abuse in the facility that were completed by an outside agency in the past 12 months. The *Prison Rape Elimination Act "PREA"* policy states that, upon review there was one allegation of sexual abuse that was referred for an outside investigation (*p.12*). The Woodward Academy will request the relevant information from the investigative agency in order to inform the resident if the agency learns that that the alleged abuser has been indicted on a charge related to sexual abuse within the facility or has been convicted *(p. 2)*.

While an outside entity conducts criminal investigation, the auditor found that when DHS investigates the facility will obtain a response in writing from DHS the results of the allegation.

115.373 (c). The facility reported in the PAQ that following a resident's allegation that a staff member has committed sexual abuse against a resident, the facility will not provide information on the staff member's presence/employment at the facility. The *Prison Rape Elimination Act "PREA"* policy, states that ffollowing a resident's allegation of sexual abuse by an employee, unless unfounded, the resident shall subsequently be informed verbally and by written documentation:

1. The staff member is no longer assigned to the resident's unit.
2. The staff member is no longer employed at 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 (*p.12*).

It was further reported that there was substantiated, or unsubstantiated complaints of sexual abuse committed by a staff member against a resident in an agency facility in the past 12 months. The facility further reported that notifications were made to the resident.

Interviews:
Executive Director: The interviewed director reported that residents will be notified of the results of the investigations upon the conclusion of the investigation.

Residents who Reported a Sexual Abuse: Four residents were interviewed who reported a sexual abuse. All of the residents reported that the incident involved another resident.

Corrective Action
Upon review of the investigative reports, it was identified that the facility did not consistently notify residents who alleged sexual abuse of the findings of the investigation. The facility will implement a corrective action and in order to determine compliance with the standard the facility shall provide a proof of notification during the corrective action phase for any allegations of sexual abuse.

During the post audit phase, the facility provided documentation of 11 notification reports. On one of the forms, it was noted that the resident was already discharged from the facility. In addition, provided documentation of two notifications that occurred during the post audit phase.

115.373 (d). The facility reported in the PAQ that it would not notify a resident on the results of an allegation that he/she was sexually abuse by another resident the results of the investigation. The *Prison Rape Elimination Act "PREA"* policy, states that ffollowing a resident's allegation of sexual abuse by an

employee, unless unfounded, the resident shall subsequently be informed verbally and by written documentation:

1. The staff member is no longer assigned to the resident's unit.
2. The staff member is no longer employed at 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 (*p.12*).

Upon further review it was found that the facility does provide notification to the residents

Documentation Reviewed
Notifications

Interviews
Residents who Reported a Sexual Abuse: Four residents who reported a sexual abuse was interviewed. Two of the four residents stated that they were never told what happened to the other resident. Two residents reported that the resident was removed from the program.

Corrective Action
Upon review of the investigative reports, it was identified that the facility did not consistently notify residents who alleged sexual abuse of the findings of the investigation. The facility will implement a corrective action and in order to determine compliance with the standard the facility shall provide a proof of notification during the corrective action phase for any allegations of sexual abuse.

During the post audit phase, the facility provided documentation of 11 notification reports. On one of the forms, it was noted that the resident was already discharged from the facility. In addition, provided documentation of two notifications that occurred during the post audit phase.

115.373 (e). As reported in the PAQ, the Woodward Academy facility does not have a policy that all notifications to residents described under this standard are documented. Upon further review, it was identified that the Prison Rape Elimination Act "PREA" policy states that "all such notifications or attempted notifications shall be documented" *(p. 2)*. There were zero reported notifications of sexual made or documented.

Corrective Action
Upon review of the investigative reports, it was identified that the facility did not consistently notify residents who alleged sexual abuse of the findings of the investigation. The facility will implement a corrective action and in order to determine compliance with the standard the facility shall provide a proof of notification during the corrective action phase for any allegations of sexual abuse.

During the post audit phase, the facility provided documentation of 11 notification reports. On one of the forms, it was noted that the resident was already discharged from the facility. In addition, provided documentation of two notifications that occurred during the post audit phase.

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

Corrective Action:
There were several areas of concern related to notification. It should also be noted that the facility did not have a policy in place to address notification. Upon review of 11 allegations of sexual abuse in the last 12 months. Approximately half of the allegations involved staff. It was also identified that the facility did not consistently notify the victim of the results of the allegation. The auditor is recommending corrective action and that the staff identify a person to conduct the notifications. It is also recommended that the

staff provide proof of the notification for any allegations of sexual abuse during the corrective action phase.

During the post audit phase, the facility provided documentation of 11 notification reports. On one of the forms, it was noted that the resident was already discharged from the facility. In addition, the facility provided documentation of two notifications that occurred during the post audit phase. The practice of conducting notifications was addressed throughout the audit phase. There are no further recommendations. The facility has addressed any deficiencies and is now in compliance with the standard.

DISCIPLINE

Standard 115.376: Disciplinary sanctions for staff

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

115.376 (a)

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

115.376 (b)

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

115.376 (c)

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

115.376 (d)

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

- Are all terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, reported to: Relevant licensing bodies? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        i. Employee Discipline
        ii. Disciplinary Sanctions for Staff
        iii. Protection Against Retaliation
    c. Investigations-11
2. Interviews:
    a. Executive Director

Findings (By Provision):

115.376 (a). The Woodward Academy facility reported in the PAQ that staff are subject to disciplinary sanctions up to and including termination for violating agency sexual abuse and sexual harassment policies. Policy & Procedures, *Disciplinary Sanctions for Staff*, states that:

> The facility has a zero-tolerance policy relating to sexual assault/harassment of a student. Any employee accused of assault of harassment will comply with any and all investigations both internal and external. Outlined below are the discipline steps involved in any and all allegations. Woodward Academy reserves the right to combine or skip steps depending upon facts of each situation and the nature of the offense. Factors that will be considered depend upon the severity of the allegation. Nothing in this policy provides any contractual rights regarding employee discipline nor should anything in this policy be read or construed as modifying or altering the employment-at-will relationship between the facility and its employees (*p. 1*).

Documentation Reviewed

The auditor reviewed 11 allegations of sexual abuse. Upon review it was identified on two occasions were either terminated or quite as a result of a sexual abuse allegation. While the allegations for sexual abuse were not substantiated, it was determined that there were improper boundaries between the staff and the resident.

115.376 (b). The Woodward Academy facility reported in the PAQ that there was one staff that violated the agency's sexual abuse or sexual harassment policies. However, in the past 12 months, zero staff were terminated for violating agency sexual abuse or sexual harassment policies. Policy & Procedures, *Disciplinary Sanctions for Staff*, states that, "termination shall be the presumptive disciplinary sanction for staff who has engaged in sexual abuse" *(p. 1)*.

Documentation Reviewed

The auditor reviewed 11 allegations of sexual abuse. Upon review it was identified on two occasions were either terminated or quite as a result of a sexual abuse allegation. While the allegations for sexual abuse were not substantiated, it was determined that there were improper boundaries between the staff and the resident.

115.376 (c). According to the PAQ, there was no disciplinary sanctions imposed during the 12-month reporting period that would apply to this standard provision. Policy & Procedures, *Protection Against Retaliation*, states that, "disciplinary sanctions for violations of agency policies relating to sexual abuse or sexual harassment shall be commensurate with the nature and circumstances of the acts committed, the staff member's disciplinary history, and the sanctions imposed for comparable offenses by other staff with similar histories" *(p. 1)*.

Documentation Reviewed
The auditor reviewed 11 allegations of sexual abuse. Upon review it was identified on two occasions were either terminated or quite as a result of a sexual abuse allegation. While the allegations for sexual abuse were not substantiated, it was determined that there were improper boundaries between the staff and the resident.

115.376 (d). According to the PAQ, there have been zero staff from the facility that have been reported to law enforcement or licensing boards following their termination for violating agency sexual abuse or sexual harassment policies. As previously stated, Policy & Procedures, *Protection Against Retaliation*, "the facility reserves the right to reassign the alleged employee to work on another dorm or suspend the employee until the completion of an investigation. The facility will make readily available victim advocates for the resident involved. All terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to any relevant licensing bodies" *(p. 2)*.

Documentation Reviewed
The auditor reviewed 11 allegations of sexual abuse. Upon review it was identified on two occasions were either terminated or quite as a result of a sexual abuse allegation. While the allegations for sexual abuse were not substantiated, it was determined that there were improper boundaries between the staff and the resident. It should also be noted that the allegations were reported to the licensing board.

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.377: Corrective action for contractors and volunteers

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

115.377 (a)

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

115.377 (b)

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

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        i. *Corrective Action for Contractors, Interns, Volunteers*
    c. Investigations-12 (One during the post onsite audit phase)
2. Interviews:
    a. Executive Director

Findings (By Provision):

115.377 (a). As reported in the PAQ, the agency policy requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement agencies and to relevant licensing bodies. There have been zero contractors or volunteers who have been reported to law enforcement for engaging in sexual abuse of residents. Policy *Volunteer/Intern/Contracted Employee Discipline*, states that "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" *(p. 1)*.

Documentation Reviewed

Based on review of files it is found that the facility meets the requirements of the standard. Upon review of 12 allegations of sexual abuse or sexual harassment, none of the allegations involved contractors or volunteers.

115.377 (b). As reported in the PAQ, the facility takes appropriate remedial measures and considers whether to prohibit further contact with residents in the case of any other violation of agency sexual abuse or sexual harassment policies by a contractor or volunteer. There have been no instances in the past 12 months where the Woodward Academy facility had to take action on a volunteer or contractor.

The facility has a policy in place to address any volunteers or contractors who violate the PREA standards of sexual abuse and sexual harassment. As stated in Policy & Procedures, *Corrective Action for Contractors, Interns, Volunteers*, states that:

> Woodward Academy has a zero-tolerance policy relating to sexual assault/harassment of a student. Any volunteer/intern/contracted employee accused of assault of harassment will comply with any and all investigations both internal and external. Upon commencement of an investigation, all contact between a volunteer/intern/contracted employee and residents will be prohibited until the investigation has been completed. In the event of exoneration upon conclusion of an investigation, no further action will be taken, and normal responsibilities will resume. If criminal or non-criminal wrongdoing is concluded, Woodward Academy shall terminate the contract of said employee or relationship with said volunteer/intern and report any criminal activity to proper law enforcement *(p. 1)*.

Interviews

Executive Director (ED): During the interview with the ED, it was reported that the facility would have the incident investigated. It was also reported that they are unaware of any such incident occurring.

Documentation Reviewed

Based on review of files it is found that the facility meets the requirements of the standard. Upon review of 12 allegations of sexual abuse or sexual harassment, none of the allegations involved contractors or volunteers.

Corrective Action:

No corrective action is recommended for this standard.

Standard 115.378: Interventions and disciplinary sanctions for residents

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

115.378 (a)

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

115.378 (b)

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

- In the event a disciplinary sanction results in the isolation of a resident, does the resident also have access to other facilities and work opportunities to the extent possible? ☒ Yes ☐ No

115.378 (c)

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

115.378 (d)

- If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, does the facility consider whether to offer the offending resident participation in such interventions? ☒ Yes ☐ No

- If the agency requires participation in such interventions as a condition of access to any rewards-based behavior management system or other behavior-based incentives, does it always refrain from requiring such participation as a condition to accessing general facility programming or education? ☒ Yes ☐ No

115.378 (e)

- Does the agency discipline a resident for sexual contact with staff only upon a finding that the staff member did not consent to such contact? ☒ Yes ☐ No

115.378 (f)

- For the purpose of disciplinary action does a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred NOT constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation? ☒ Yes ☐ No

115.378 (g)

- If the agency prohibits all sexual activity between residents, does the agency always refrain from considering non-coercive sexual activity between residents to be sexual abuse? (N/A if the agency does not prohibit all sexual activity between residents.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        i. Prison Rape Elimination Act "PREA"
        ii. Disciplinary Sanctions for Residents
    c. PREA Student Orientation Book
    d. Investigations-12 (one during the post onsite audit phase)
2. Interviews:
    a. Executive Director
    b. Medical and mental health staff - 2

Findings (By Provision):

115.378 (a). As reported in the PAQ, residents are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that a resident engaged in resident-on-resident sexual abuse. Per the PAQ, there were no administrative or criminal findings of resident-on-resident sexual abuse that occurred at the facility in the last 12 months.

Policy & Procedures, *Disciplinary Sanctions for Residents*, establishes a policy "to determine disciplinary action for residents who engage in resident-on-resident sexual abuse as sexual activity of any type is prohibited at this facility" *(p. 1)*.

Documentation Reviewed

Upon review of 12 allegations of sexual abuse or sexual harassment, there were no substantiated allegations of sexual abuse or sexual harassment involving residents. While none of the allegations were substantiated it was determined that the facility put a safety plan in place to further monitor interactions.

115.378 (b). The facility does not utilize isolation. Policy & Procedures, *Disciplinary Sanctions for Residents*, states that, "any disciplinary action shall be commensurate with the nature and circumstances of the abuse committed, with the resident's disciplinary history and the sanctions imposed for comparable offenses by other residents with similar histories" *(p. 1)*.

Documentation Reviewed

Upon review of 12 allegations of sexual abuse or sexual harassment, there were no substantiated allegations of sexual abuse or sexual harassment involving residents. While none of the allegations were substantiated it was determined that the facility put a safety plan in place to further monitor interactions.

Interviews

Executive Director (ED): The interviewed ED reported that they would take everything into consideration when making decisions. The facility would let law enforcement/juvenile court officer/DHS worker handle criminal cases and the sanctions that are imposed. The facility does not use isolation.

115.378 (c). Policy & Procedures, *Disciplinary Sanctions for Residents*, "indicated that, "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 discipline, if any, should be imposed" *(p. 1)*.

Documentation Reviewed

Upon review of 11 allegations of sexual abuse or sexual harassment, there were no substantiated allegations of sexual abuse or sexual harassment involving residents. While none of the allegations were substantiated it was determined that the facility put a safety plan in place to further monitor interactions.

Interviews

Executive Director: The interviewed director reiterated that the Woodward Academy facility would take everything into consideration; and make assignments based on the situation. They will assess whether the youth will remain in the facility and/or referred for criminal charges.

115.378 (d). Per the PAQ, the Woodward Academy facility offers therapy, counseling and other interventions designed to address and correct underlying reasons or motivations for the abuse; and the facility shall consider whether to require the offending resident to participate in such interventions as a condition of access to facility programming or other benefits.

Documentation Reviewed

Upon review of 12 allegations of sexual abuse or sexual harassment, there were no substantiated allegations of sexual abuse or sexual harassment involving residents. While none of the allegations were substantiated it was determined that the facility put a safety plan in place to further monitor interactions. It should also be noted that the facility has an onsite program to address sexually abusive behaviors.

Interviews

Medical and Mental Health Staff: Interviews with the medical and mental health staff, indicated that all residents are offered individual and group related services; and perpetrating services would be offered. When services are provided, it is voluntary participating, with the expectation that they will participate; however, it is not tied to a reward-based system. Woodward Academy campus has an adolescent sexual offender unit. We work with victims and offenders in all areas of our clinical department. Woodward Academy has a PBS, Positive Behavior System that is utilized for all of treatment, not for what is discussed in clinical services. The students have the opportunity to earn points throughout the week to go to the campus store and spend their points. All students start with one and can move up from there. In addition, provides 24/7 programming with on campus education certified by the State Board of Education.

115.378 (e). As reported in the PAQ, the Woodward Academy disciplines resident for sexual contact with staff only upon finding that the staff member did not, consent to such contact. Policy & Procedures, *Disciplinary Sanctions for Residents*, states that, “ddisciplinary action will only be considered for resident sexual contact with a staff member if there is an administrative or criminal finding that the staff member did not consent to such contact” *(p. 1)*. There were zero reported allegations of sexual abuse or sexual harassment in which a resident displayed inappropriate sexual contact with a staff member.

115.378 (f). As reported in the PAQ, the facility prohibits disciplinary action for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation. Policy & Procedures, *Disciplinary Sanctions for Residents*, distinguishes that “the facility prohibits disciplinary actions for a report of sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred, even if an investigation does not establish evidence sufficient to substantiate the allegation” *(p. 2)*.

Documentation Reviewed

Upon review of 12 allegations of sexual abuse or sexual harassment, there were no substantiated allegations of sexual abuse or sexual harassment involving residents. The auditor did not observe any instances where anyone was disciplined for reported an allegation of sexual abuse out of good faith.

115.378 (g). As reported in the PAQ, that facility prohibits sexual activity between residents. Policy & Procedures, *Disciplinary Sanctions for Residents*, states that, "the facility in its discretion, prohibit all sexual activity between residents and may discipline residents for such activity" *(p. 2)*. Additional it states that an agency may not, however, deem such activity to constitute sexual abuse if it determines that the activity is not coerced.

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

Corrective Action:

No corrective action is recommended for this standard.

MEDICAL AND MENTAL CARE

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

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

115.381 (a)

- If the screening pursuant to § 115.341 indicates that a resident has experienced prior sexual victimization, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (b)

- If the screening pursuant to § 115.341 indicates that a resident has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, do staff ensure that the resident is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening? ☒ Yes ☐ No

115.381 (c)

- Is any information related to sexual victimization or abusiveness that occurred in an institutional setting strictly limited to medical and mental health practitioners and other staff as necessary to inform treatment plans and security management decisions, including housing, bed, work, education, and facility assignments, or as otherwise required by Federal, State, or local law? ☒ Yes ☐ No

115.381 (d)

- Do medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        i. Medical Services
        ii. Prison Rape Elimination Act "PREA"
        iii. *Access to Emergency Medical, and Mental Services*
    c. Resident Files (20):
        i. PREA Assessment
        ii. PREA Reassessment
        iii. Psychosocial Assessment
        iv. *Nurse Intake Assessment Form* – 20
        v. Housing Placement-20
        vi. Parent Student Handbook
    d. Follow up after report of sexual abuse
2. Interviews:
    a. Staff responsible for Risk Screening - 1
    b. Medical and mental health staff – 2
    c. Residents who reported a prior history of sexual abuse- 6

Findings (By Provision):

115.381 (a). As reported in the PAQ, residents at the facility who disclosed any prior sexual victimization during a screening pursuant to 115.341 are offered a follow-up meeting with a medical or mental health practitioner. The Woodward Academy reported in the PAQ, that 100 of the residents who reported prior victimization during screening were offered a follow-up meeting with a medical or mental health practitioner. Policy & Procedures, *Access to Emergency Medical, and Mental Services*, states that, "the facility will ensure the following:

1. If it is indicated during the screening pursuant to Juvenile PREA Standard 115.341 that a student has experienced prior sexual victimization (regardless of the setting), staff conducting the screening will ensure the student is aware they may follow up on the subject with a medical professional during their new admission physical, which takes place within seven days of their admission.
2. If it is indicated during the screening pursuant to 115.341 that the student has previously perpetrated sexual abuse (regardless of the setting), staff conducting the screening will ensure that the student has a follow up appointment scheduled with the Woodward Academy Therapist within 72 hours. Woodward Academy is a facility for residents with co-occurring mix of disruptive behaviors, psychiatric symptoms, and substance abuse problems" *(p. 1)*.

<u>Documentation Reviewed</u>

- A review of 20 resident files, confirmed that residents are screened within the time frames of this standard. In addition, all of the residents received a follow up meeting via a reassessment and a psychosocial assessment.
- Follow up with medical and mental health

<u>Interviews</u>

Residents who Disclose Sexual Victimization at Risk Screening: Six of the interviewed residents were interviewed that reported a prior history of sexual abuse during the risk screening. The residents stated that they were asked if the wanted to follow up services. Two of the six residents stated that they refused additional services and four residents stated that they are currently in treatment for prior history of sexual abuse.

Staff Responsible for Risk Screening: One of the interviewed staff responsible for risk screening stated that if a screening indicates that a resident has experienced prior sexual victimization whether in an institutional setting or in the community; follow up medical or mental health services would be offered. This would occur immediately.

115.381 (b). As stated previously, residents that have previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, will be offered a follow up meeting with a mental health practitioner. It was also reported that the intake process includes an automatic meeting with the medical and mental health staff. The same level of services is offered for residents who have previously perpetrated sexual abuse. The facility also reported that 100% of the residents who disclosed prior victimization during screening were offered a follow up meeting with a mental health practitioner.

Documentation Reviewed

- A review of 20 resident files, confirmed that residents are screened within the time frames of this standard. In addition, all of the residents received a follow up meeting via a reassessment and a psychosocial assessment.
- Follow up with medical and mental health

Interviews

Staff Responsible for Risk Screening: The interviewed staff reported that if a screening indicates that a resident previously perpetrated sexual abuse mental health services are offered. All residents have an assigned therapist. If needed other services are offered.

115.381 (c). Policy & Procedures, *Access to Emergency Medical, and Mental Services*, states that, "any information regarding a resident related to sexual victimization or abusiveness that occurred shall be shared as necessary for the development of treatment plans, behavior support plans, safety plans and education planning, or as otherwise required by federal, state, or local law" *(p. 1)*.

115.381 (d). As reported in the PAQ, medical and mental health practitioners obtain informed consent from residents before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the resident is under the age of 18. The Woodward Academy facility policy indicates that "medical and mental health practitioners will 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, consent must be obtained by the facility staff prior to reporting sexual abuse that did not occur in an institutional setting" (p. 2).

Documentation Reviewed

- Upon admission into the facility, medical staff attains informed consent (Conditions of Admission) from the resident and the parents.

Interviews

Medical and Mental Health Staff: Medical and mental health staff confirmed informed consent from residents is required for residents 18 and older, before reporting prior sexual victimization that occurred in an institutional setting. This is one of the admitting assessments. It is addressed in the PREA questionnaire and then again in the psychosocial evaluation that is completed within five days with their clinician. We address with the youth the questions that we will be asking, we do not have them sign that they are specifically consent to this information, if they choose not to respond that is noted as their right. We usually receive all this information from the referring agent and family as well. We have the student and the parent complete the Conditions of Admission that includes all the consents required for the youth to partake in all aspects of their program.

The review of documentation provided evidence of staff compliance with the standard.

Corrective Action:
The following items are pending and will need to be provided in order to determine compliance:
What documentation is used for the follow up with medical and mental health after the initial assessment and the resident indicates a prior history of victimization. I know that a reassessment is conducted but is there a treatment plan which shows services offered as a follow up? If so, please upload a sample of 10 treatment plans for residents with prior hx of victimization and 10 residents with prior history of perpetration. During the post audit phase, the facility provided the treatment plans that are conducted within 14 days. The plans address prior history of victimization and perpetration.

Standard 115.382: Access to emergency medical and mental health services

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

115.382 (a)

- Do resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by medical and mental health practitioners according to their professional judgment? ☒ Yes ☐ No

115.382 (b)

- If no qualified medical or mental health practitioners are on duty at the time a report of recent sexual abuse is made, do staff first responders take preliminary steps to protect the victim pursuant to § 115.362? ☒ Yes ☐ No

- Do staff first responders immediately notify the appropriate medical and mental health practitioners? ☒ Yes ☐ No

115.382 (c)

- Are resident victims of sexual abuse offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate? ☒ Yes ☐ No

115.382 (d)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        i. Medical Services
        ii. Access to emergency medical and mental services
    c. Resident Files (20):
        i. PREA Assessment (tab12)
        ii. PREA Reassessment
        iii. Psychosocial Assessment (tab 13)
        iv. *Nurse Intake Assessment Form* – 20
        v. Housing Placement-20
        vi. Parent Student Handbook (tab 14)
2. Interviews:
    a. Medical and mental health staff - 2
    b. Security staff and non-security staff first responders-12
    c. Resident who reported sexual abuse - 4

Findings (By Provision):

115.382 (a). As reported in the PAQ, resident victims of sexual abuse receive timely, unimpeded access to emergency medical treatment and crisis intervention services. It further stated that the nature and scope of such services are determined by medical and mental health practitioners according to their professional judgement.

<u>Interviews</u>

Medical and Mental Health Staff: Two interviewed mental health and medical staff reported that victims of sexual abuse receive timely and unimpeded access to emergency medical treatment and crisis intervention services. Such services are rendered immediately upon notification. When sexual abuse is presented policies and procedures follow this. In several cases youth are sent to the Blank Children's Hospital to participate in a STAR investigation. Beyond what is offered in this program, the trauma of the even is addressed with their therapist. The medical staff indicated that they offer medical treatment and crisis intervention services. If immediate medical attention is needed the child is taken to Perry Hospital or Blank Children's Hospital depending on the detriment of the abuse. The youth's therapist is notified, and they will check in with him on their mental status and address things on the youth's emotional level at the time. The medical staff reported that such services would not be solely the judgement of onsite staff.

Residents who Reported a Sexual Abuse: One of the four residents who reported sexual abuse reported that they spoke to mental health shortly after the incident. The follow up occurred shortly after making the allegation.

Upon review, one allegation was sexual harassment and the one that was related to sexual abuse, the resident did receive follow up services with the counselor.

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

115.382 (b). Twelve of the direct care staff interviewed, as staff who act as first responders, reported that the duties of a first responder include, but are not limited to: take immediate action, stay with the resident, separate the victim from the perpetrator, isolate/secure the scene and secure evidence, call for additional staff, and notify supervisor. It should be noted that all of the direct care staff who work in the facility are considered and trained as first responders.

Documentation Reviewed

Notification to medical and mental health

Interviews

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

115.382 (c). As reported in the PAQ, resident victims of sexual abuse while incarcerated are offered timely information about and timely access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.

Documentation Reviewed

Follow up with medical /mental health

Interviews

Medical and Mental Health Staff: The interviewed medical and mental health staff reported that such services are addressed immediately.

Residents who Reported a Sexual Abuse: Two of the four residents who reported sexual abuse stated that after the incident they continued to discuss the incident with their therapist. The incident was incorporated into the regular treatment. Upon review of the allegations, the allegations did not require emergency medical services.

115.382 (d). As reported in the PAQ, the treatment services provided to every victim is without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out the incident. Policy & Procedures, *Access to Emergency Medical, and Mental Services*, states that, "all medical and mental health services provided to a student will be at no cost to the victim. All other treatment services provided will be at no cost to the victim" *(p. 3)*.

Treatment services are provided to every victim without financial cost regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.

Corrective Action:

The following items are pending and will need to be provided in order to determine compliance:
For the allegations of sexual abuse that occurred in the last 12 months, provide verification that the residents were offered follow up medical and mental health services. This is an automatic and not contingent on the results of the allegation. If services were not offered, we will need to monitor any pending or upcoming allegations to ensure compliance with the standard.

During the post audit phase, the facility provided verification of follow up with medical/mental health on allegations that occurred in the post audit phase.

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

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

115.383 (a)

- Does the facility offer medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility? ☒ Yes ☐ No

115.383 (b)

- Does the evaluation and treatment of such victims include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody? ☒ Yes ☐ No

115.383 (c)

- Does the facility provide such victims with medical and mental health services consistent with the community level of care? ☒ Yes ☐ No

115.383 (d)

- Are resident victims of sexually abusive vaginal penetration while incarcerated offered pregnancy tests? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☐ Yes ☐ No ☒ NA

115.383 (e)

- If pregnancy results from the conduct described in paragraph § 115.383(d), do such victims receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services? (N/A if "all-male" facility. *Note: in "all-male" facilities, there may be residents who identify as transgender men who may have female genitalia. Auditors should be sure to know whether such individuals may be in the population and whether this provision may apply in specific circumstances.*) ☐ Yes ☐ No ☒ NA

115.383 (f)

- Are resident victims of sexual abuse while incarcerated offered tests for sexually transmitted infections as medically appropriate? ☒ Yes ☐ No

115.383 (g)

- Are treatment services provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident? ☒ Yes ☐ No

115.383 (h)

- Does the facility attempt to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offer treatment when deemed appropriate by mental health practitioners? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        i. Prison Rape Elimination Act "PREA"
        ii. PREA Zero Tolerance
    c. Follow up after sexual abuse allegation (2)
2. Interviews:
    a. Medical and mental health staff – 2
    b. Resident who reported sexual abuse - 4

Findings (By Provision):

115.383 (a). As reported in the PAQ, the facility offers medical and mental health evaluation and, as appropriate, treatment to all residents who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility. The Prison Rape Elimination Act "PREA" policy states that the facility will provide counseling services and/or medical assistance if victimized (*p. 3*). The policy further states that "the victim of sexual assault/rape or attempted sexual assault/rape must be provided mental health assistance and counseling as determined necessary and appropriate" (8).

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

185.383 (b). The evaluation and treatment of such victims shall include, as appropriate, follow-up services, treatment plans, and, when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or their release from custody.

<u>Documentation Reviewed</u>
Treatment Plans

Interviews

Medical and Mental Health Staff: The interviewed medical and mental health staff stated that evaluation and treatment of residents who have been victimized entails: The youth's clinician continues to meet with the student and follow up on trauma-based emotions while residing in our care. Following discharge from our care, it is addressed with the family aftercare treatment that would include therapy, medication management, physical health, education, etc. The treatment team that includes the family and youth are involved in this process to be directed to appropriate mental health and trauma services.

Residents who Reported a Sexual Abuse: Four residents who reported a sexual abuse were interviewed. Only one stated that they met with the therapist one time.

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

Interviews

Medical and Mental Health Staff: As reported by the interviewed medical and mental health staff, the treatment and services provided are consistent with the community level of care. There is a shared continuity of care, however many of these services for the youth are voluntary. The treatment plan following discharge is at the discretion of the parents and referring DHS or Juvenile Court Officer.

115.383 (d). As reported in the PAQ, female victims of sexual abusive vaginal penetration while incarcerated are offered pregnancy tests.

Policy PREA Zero Tolerance states that "ffollowing emergency response and completion of the rape kit (if applicable) a client believed or determined to have been the victim of a sexual assault/rape must also be examined by medical staff for possible injuries, regardless of when the alleged sexual assault occurred. Female clients must be provided with pregnancy tests" (*p*. 5)

Interviews

Residents who Reported a Sexual Abuse if Female: There were no identified residents onsite who reported a sexual abuse.

115.383 (e). As reported in the PAQ, if pregnancy results from sexual abuse while incarcerated, victims receive timely and comprehensive information about, and timely access to, all lawful pregnancy-related medical services.

Policy Access to emergency medical and mental services states that "if pregnancy results from sexually abusive penetration, the CARES center will provide timely and comprehensive information about, and timely access to, all lawful pregnancy-related medical services" (*p. 2*).

Interviews

Medical and Mental Health Staff: The interviewed medical and mental health staff stated if pregnancy results from sexual abuse while incarcerated victims are given timely information and access to all lawful pregnancy-related services. The youth have the opportunity to ask for a pregnancy test at any point in their treatment. There are strong confidential rules that contain this information solely to the medical professionals. When an incident is presented, the PREA officer will address this information and what the youth would want. The clinical of that youth will also follow up with what they need or what they may want at that point in time. In addition, staff would work with the local community healthcare providers.

Residents who Reported a Sexual Abuse if Female: There were no identified female residents onsite who reported a sexual abuse.

115.383 (f). As reported in the PAQ, resident victims of sexual abuse while incarcerated are offered tests for sexually transmitted infections as medically appropriate. Woodward Academy staff will ensure that residents of sexual abuse are provided a sexually transmitted infections test, along with receiving any necessary follow up medical care. The Prison Rape Elimination Act "PREA" policy states that "victims and perpetrators of sexual assault must be encouraged to completed tests for sexually transmitted disease, including HIR. In the case of a substantiated incident of sexual assault, the perpetrator must be requested to complete an HIV test. If the perpetrator will not voluntarily take an HIV test, the Executive Director or designee must seek a court order compelling the test" (p. 8).

Interviews
Residents who Reported a Sexual Abuse: Four interviewed residents who reported sexual abused stated that they did not receive information regarding preventing sexually transmitted infections or contraception. Resident was not seen by medical to receive a test for infections test. Upon review, the allegations would not have necessitated offering such services.

115.383 (g). Policy & Procedures, *Access to Emergency Medical, and Mental Services*, states that, "all medical and mental health services provided to a student will be at no cost to the victim. All other treatment services provided will be at no cost to the victim" *(p. 3)*.

Residents who Reported a Sexual Abuse: Four interviewed residents who reported sexual abuse stated that they were unaware of any fees for treatment that they or their parents would be responsible for after the incident. The facility provides treatment services without financial cost to the victims.

115.383 (h). As reported in the PAQ, the Woodward Academy facility, attempts to conduct a mental health evaluation of all known resident-on-resident abusers within 60 days of learning of such abuse history and offers treatment when deemed appropriate by mental health practitioners. It should also be noted that the program provides onsite treatment for residents with sexually abusive behaviors.

Documentation Reviewed
Follow up with medical and mental health

Interviews

Medical and Mental Health: The interviewed medical and mental health staff reported that this may not be a full psychiatric assessment, but the clinician will meet with the youth to process the incident and where they are at mentally. We have to be very careful when processing abuse as to not revictimize. We meet them on their level.

Corrective Action:
The following items are pending and will need to be provided in order to determine compliance:

- For the allegations of sexual abuse that occurred in the last 12 months, provide verification that the residents were offered follow up medical and mental health services. This is an automatic and not contingent on the results of the allegation. If services were not offered, we will need to monitor any pending or upcoming allegations to ensure compliance with the standard. During the post audit phase, the facility provided documentation of follow-up with medical and mental health to show compliance with the standard. There is no further action needed to show compliance with the standard.

DATA COLLECTION AND REVIEW

Standard 115.386: Sexual abuse incident reviews

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

115.386 (a)

- Does the facility conduct a sexual abuse incident review at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation has been determined to be unfounded? ☒ Yes ☐ No

115.386 (b)

- Does such review ordinarily occur within 30 days of the conclusion of the investigation? ☒ Yes ☐ No

115.386 (c)

- Does the review team include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners? ☒ Yes ☐ No

115.386 (d)

- Does the review team: Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse? ☒ Yes ☐ No
- Does the review team: Consider whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status, or perceived status; gang affiliation; or other group dynamics at the facility? ☒ Yes ☐ No
- Does the review team: Examine the area in the facility where the incident allegedly occurred to assess whether physical barriers in the area may enable abuse? ☒ Yes ☐ No
- Does the review team: Assess the adequacy of staffing levels in that area during different shifts? ☒ Yes ☐ No
- Does the review team: Assess whether monitoring technology should be deployed or augmented to supplement supervision by staff? ☒ Yes ☐ No
- Does the review team: Prepare a report of its findings, including but not necessarily limited to determinations made pursuant to §§ 115.386(d)(1) - (d)(5), and any recommendations for improvement and submit such report to the facility head and PREA compliance manager? ☒ Yes ☐ No

115.386 (e)

- Does the facility implement the recommendations for improvement, or document its reasons for not doing so? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        i. Prison Rape Elimination Act "PREA"
        ii. PREA Zero Tolerance
        iii. Sexual Abuse Incident Reviews
    c. PREA Incident Review (11)
2. Interviews:
    a. Executive Director
    b. PREA compliance manager
    c. Incident review team - 2

Findings (By Provision):

115.386 (a). As reported in the PAQ, the Woodward Academy facility, conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigation, unless the allegation has been determined to be unfounded. The *Prison Rape Elimination Act "PREA"* policy states that "facility management must review each incident of sexual abuse for cause, staffing, and physical barriers, and make recommendations for prevention and implementation of remedy (s) *(p. 14)*.

Documentation Reviewed

The auditor reviewed 11 allegations of sexual abuse that received in incident review in the last 12 months. The incident reviews were conducted using the above-mentioned policy guidelines.

115.386 (b). There were 11 reported criminal and/or administrative investigations of alleged sexual abuse completed within 30 days, excluding unfounded incidents.

115.386 (c). As reported in the PAQ, the sexual abuse incident review team includes upper-level management officials and allows for input from line supervisors, investigators, and medical or mental health practitioners. Policy *PREA Zero Tolerance*, states that, "the facility management team must review each incident of sexual abuse for cause, staffing, and physical barriers, and make recommendations for prevention and implementation of remedy(s)" *(p. 7)*.

Documentation Reviewed

The auditor reviewed 11 allegations of sexual abuse that received an incident review within the required timeframes and involving upper management staff.

Interviews

Executive Director (ED): The interviewed ED reported that the facility has a sexual abuse incident review team. This is an inter-disciplinary team including upper-level management, supervisors, investigators, medical and nursing professionals.

115.386 (d). As reported in the PAQ, the facility prepares a report of its findings from sexual abuse incident reviews including but not limited to determination made and any recommendations for improvement and submits such report to the facility head and PREA compliance manager. Policy & Procedures, *Sexual Abuse Incident Reviews*, indicated that the review team shall:

1. Consider whether the allegation or investigation indicates a need to change policy or practice to better prevent, detect, or respond to sexual abuse.
2. Consider whether the incident or allegation was motivated by race, ethnicity, gender identity, lesbian, gay, bisexual. transgender, or intersex identification or perceived status; or gang affiliation; or group dynamics.
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 (*p. 1*).

Documentation Reviewed
Incident Reviews (11)

Interviews
Executive Director (ED): The interviewed ED reported that the facility has a sexual abuse incident review team. The team uses the information from the sexual abuse incident review to determine if there are gaps. The facility will action plan and create procedures to close said gaps. The facility is constantly looking for ways to improve and utilize any reviews as a way to do this the QA Director along with the management team monitors and makes sure things go full circle after issues and plans are identified. The review team considers the above-mentioned areas.

PREA Compliance Manager: The interviewed PCM reported that all of the above areas are taken into consideration. Upon conclusion of the investigation, results are reviewed in a meeting including all management team. The PCM will complete the reports. The only trends observed is that a majority of the allegations are unsubstantiated or unfounded. The reports are reviewed with the management team.

Incident Review Team: Two interviewed staff who is a part of the incident review team reported that the Woodward Academy takes into consideration whether the incident or allegation was motivated by race; ethnicity; gender identity; lesbian, gay, transgender, or intersex identification, status, or perceived status; gang affiliation; or was motivated or otherwise caused by other group dynamics at the facility. They review is documented on the PREA incident review form. They review the entire incident from beginning to end and part of that does include a discussion about the “issue behind the issue’ or what else could have contributed to the particular incident. All potential avenues are explored and discussed as the goal would be to learn from these situations to prevent future occurrences. Some of the other areas would be to discuss the physical plant and where the incident occurred and camera review.

115.386 (e). As reported in the PAQ, the Woodward Academy facility, implements the recommendations for improvement of documents its reasons for not doing so. The *PREA Zero Tolerance* Policy states that “the Facility Management Team must review each incident of sexual abuse for cause, staffing, and physical barriers, and make recommendations for prevention and implementation of remedy(s)” (*p. 7*).

Documentation Reviewed

Incident Reports

Corrective Action:
No corrective action is recommended for this standard.

Standard 115.387: Data collection

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

115.387 (a)

- Does the agency collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control using a standardized instrument and set of definitions? ☒ Yes ☐ No

115.387 (b)

- Does the agency aggregate the incident-based sexual abuse data at least annually? ☒ Yes ☐ No

115.387 (c)

- Does the incident-based data include, at a minimum, the data necessary to answer all questions from the most recent version of the Survey of Sexual Violence conducted by the Department of Justice? ☒ Yes ☐ No

115.387 (d)

- Does the agency maintain, review, and collect data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews? ☒ Yes ☐ No

115.387 (e)

- Does the agency also obtain incident-based and aggregated data from every private facility with which it contracts for the confinement of its residents? (N/A if agency does not contract for the confinement of its residents.) ☐ Yes ☐ No ☒ NA

115.387 (f)

- Does the agency, upon request, provide all such data from the previous calendar year to the Department of Justice no later than June 30? (N/A if DOJ has not requested agency data.) ☐ Yes ☐ No ☒ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        i. Prison Rape Elimination Act "PREA"
    c. SSV Report (2020)
    d. Annual Report
2. Interviews:
    a. Executive Director

Findings (By Provision):

115.387 (a/c). As reported in the PAQ, the Woodward Academy facility, reviewed data collected and aggregated under its direct control to assess and improve the effectiveness of the facility's sexual abuse prevention, detection, and response policies, practices, and training, including by identifying problem areas, taking corrective action on an ongoing basis. The *Prison Rape Elimination Act "PREA"* policy states that "the facility must collect accurate, uniform data for every allegation of sexual abuse. At a minimum the data must be sufficient to answer all questions on the annually required Survey of Sexual Violence data must be:

a. Reviewed in order to assess and improve sexual abuse prevention, detection, and response practices.
b. Made available to the public through public Website or some other means at least annually, NOTE: Personal identifies must be removed. *(p. 14)*.

The last completed agency annual report was posted on the agency website: Woodward_PREA_Report_2018.pdf (wwacademy.com).

115.387 (b). As reported in the PAQ, the agency aggregates incident-based sexual abuse data annually.

115.387 (d). As reported in the PAQ, the agency maintains, reviews, and collects data as needed from all available incident-based documents, including reports, investigation files, and sexual abuse incident reviews. The Prison Rape Elimination Act "PREA" policy states that "the facility must collect accurate, uniform data for every allegation of sexual abuse. At a minimum the data must be sufficient to answer all questions on the annually required Survey of Sexual Violence data must be:

a. Reviewed in order to assess and improve sexual abuse prevention, detection, and response practices.
b. Made available to the public through public Website or some other means at least annually, NOTE: Personal identifies must be removed. *(p. 14)*.

The facility provided a copy of the agency annual report. No further action is needed.

115.387 (e.) NA the agency does not contract for the confinement of its residents.

115.387 (f). NA the DOJ has not requested agency data.

Corrective Action:
The following items are pending and will need to be provided in order to determine compliance:

- Provide a copy of the agency annual report. The facility annual report was provided. There is no further action needed for this standard.

Standard 115.388: Data review for corrective action

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

115.388 (a)

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Identifying problem areas? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Taking corrective action on an ongoing basis? ☒ Yes ☐ No

- Does the agency review data collected and aggregated pursuant to § 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training, including by: Preparing an annual report of its findings and corrective actions for each facility, as well as the agency as a whole? ☒ Yes ☐ No

115.388 (b)

- Does the agency's annual report include a comparison of the current year's data and corrective actions with those from prior years and provide an assessment of the agency's progress in addressing sexual abuse ☒ Yes ☐ No

115.388 (c)

- Is the agency's annual report approved by the agency head and made readily available to the public through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.388 (d)

- Does the agency indicate the nature of the material redacted where it redacts specific material from the reports when publication would present a clear and specific threat to the safety and security of a facility? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        i. Prison Rape Elimination Act "PREA"
    c. Annual Report
2. Interviews:
    a. Agency head
    b. PREA coordinator
    c. PREA compliance manager

Findings (By Provision):

115.388 (a). As reported in the PAQ, the agency reviews data collected and aggregated pursuant 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, and training, including:

- Identified problem areas.
- Taking corrective action on an ongoing basis; and
- Preparing an annual report of its findings from its data review and corrective actions for each facility, as well as the agency as a whole.

The Prison Rape Elimination Act "PREA" policy states that "the facility must collect accurate, uniform data for every allegation of sexual abuse. At a minimum the data must be sufficient to answer all questions on the annually required Survey of Sexual Violence data must be:

a. Reviewed in order to assess and improve sexual abuse prevention, detection, and response practices.
b. Made available to the public through public Website or some other means at least annually, NOTE: Personal identifies must be removed. *(p. 14)*.

<u>Interviews</u>

Agency Head: The interviewed agency head stated that through the internal risk management reporting system, information on occurrences of alleged, substantiated, and substantiated allegations of sexual abusive is collected by the agency. The data is regularly aggregated and reviewed by agency leadership to identify positive and negative trends, problematic areas, and opportunities for improvement (proactive) or corrective action (reactive). It is the agency's requirement that each facilitate participate in a similar process of reviewing sexual abuse data, identifying trends and problem areas, and develop action plans accordingly. Each facility must provide the agency with an annual report of its findings and action plans, so that agency leadership can review the collective reports. It is the agency's policy that these reports be made readily available as required by policy, law, and regulation.

PREA Coordinator: The interviewed PREA coordinator stated that the agency reviews data collected and aggregated pursuant to 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies and training. The agency enforces access controls in the electronic medical record platform and any relevant software systems.

PREA compliance manager: The interviewed PREA compliance manager reported that the Woodward Academy facility reviews data collected and aggregated to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training. The facility would look for trends in abuse allegations and come up with a corrective action plan if it is felt that there were any strong trends in areas of risk for future allegations. The agency will prepare an annual report. The agency began operations less than 6 months ago.

The facility provided a copy of the facility annual report. No further action is needed.

115.388 (b). As reported in the PAQ, the annual report does not include a comparison of the current year's data and corrective actions with those from prior years. In addition, the annual report provides an assessment of the agency's progress in addressing sexual abuse. The facility provided a copy of the agency annual report. No further action is needed.

115.388 (c). As reported in the PAQ, the agency makes its annual report readily available to the public at least annually through its website. The annual reports are approved by the agency head; however, with the new merger of the agencies such reports have not been submitted yet to the new agency. The facility provided a copy of the agency annual report. No further action is needed.

115.388 (d). When complete the above-mentioned reports, names and descriptors are not used in the annual summary. The material not included in the annual summary is noted on the facility website. The Prison Rape Elimination Act "PREA" policy states that "the facility must collect accurate, uniform data for every allegation of sexual abuse. At a minimum the data must be sufficient to answer all questions on the annually required Survey of Sexual Violence data must be:

a. Reviewed in order to assess and improve sexual abuse prevention, detection, and response practices.
b. Made available to the public through public Website or some other means at least annually, NOTE: Personal identifies must be removed. *(p. 14)*.

<u>Interviews</u>

PREA Coordinator: The interviewed PREA coordinator stated that the agency will redact client/resident identifying information, facility full names and addresses. This is removed for the privacy of the clients and the security of the facilities.

Corrective Action:
The following items are pending and will need to be provided in order to determine compliance:
Provide a copy of the facility annual report. A copy of the facility annual report was provided. No further action is needed.

Standard 115.389: Data storage, publication, and destruction

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

115.389 (a)

- Does the agency ensure that data collected pursuant to § 115.387 are securely retained? ☒ Yes ☐ No

115.389 (b)

- Does the agency make all aggregated sexual abuse data, from facilities under its direct control and private facilities with which it contracts, readily available to the public at least annually through its website or, if it does not have one, through other means? ☒ Yes ☐ No

115.389 (c)

- Does the agency remove all personal identifiers before making aggregated sexual abuse data publicly available? ☒ Yes ☐ No

115.389 (d)

- Does the agency maintain sexual abuse data collected pursuant to § 115.387 for at least 10 years after the date of the initial collection, unless Federal, State, or local law requires otherwise? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Pre-Audit Questionnaire (PAQ)
    b. Policy:
        i. PREA Zero Tolerance
        ii. Data Collection
    c. Annual Report
2. Interviews:
    a. PREA coordinator

Findings (By Provision):

115.389 (a). The Woodward Academy facility reported in the PAQ that incident-based and aggregate data is securely retained. Policy & Procedures, *Data Collection*, provides that "All data collected will be retained for at least 10 years after the date of the data's initial collection on a secured electronic database as well as a hard copy in a secured location, accessible only by the management team" *(p. 2)*.

PREA Coordinator: The interviewed PREA coordinator, reported that the agency reviews data collected and aggregated pursuant to 115.387 in order to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies and training. The agency enforces access controls in the electronic medical record platform and any relevant software systems, along with any needed corrective action measures.

115.389 (b). As reported in the PAQ, the agency policy requires that aggregated sexual abuse data from facilities under its direct control and private facilities with which it contracts be made readily available to the public at least annually through its website. Policy *PREA Zero Tolerance* states that "the agency must distribute information to the public on how to report sexual abuse and sexual harassment on behalf of clients, information on its zero-tolerance policy for sexual abuse/rape of clients, and sexual abuse data reports" (*p. 7*). The policy further states that "The facility must collect accurate, uniform data for every allegation of sexual abuse. At a minimum the data must be sufficient to answer all questions on the annually required Survey of Sexual Victimization. Aggregated data must be:

a. Reviewed in order to assess and improve sexual abuse prevention, detection, and response practices.
b. Made available to the public through a public website or some other means at least annually, NOTE: Personal identifiers must be removed (*p. 8)*

The facility provided a copy of the annual report.

115.389 (c). As reported in the PAQ, the facility shall remove all personal identifiers before making aggregate sexual abuse data public.

115.389 (d). Policy & Procedures, *Data Collection*, indicates that "all data collected will be retained for at least 10 years after the date of the data's initial collection on a secured electronic database as well as a hard copy in a secured location, accessible only by the management team" *(p. 2)*.

Corrective Action:

The following items are pending and will need to be provided in order to determine compliance:
Provide a copy of the facility annual report. A copy of the facility annual report was provided. No further action is needed.

AUDITING AND CORRECTIVE ACTION

Standard 115.401: Frequency and scope of audits

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

115.401 (a)

- During the prior three-year audit period, did the agency ensure that each facility operated by the agency, or by a private organization on behalf of the agency, was audited at least once? (*Note:*

The response here is purely informational. A "no" response does not impact overall compliance with this standard.) ☒ Yes ☐ No

115.401 (b)

- Is this the first year of the current audit cycle? (*Note: a "no" response does not impact overall compliance with this standard*.) ☐ Yes ☒ No
- If this is the second year of the current audit cycle, did the agency ensure that at least one-third of each facility type operated by the agency, or by a private organization on behalf of the agency, was audited during the first year of the current audit cycle? (N/A if this is **not** the *second* year of the current audit cycle.) ☐ Yes ☐ No ☒ NA
- If this is the third year of the current audit cycle, did the agency ensure that at least two-thirds of each facility type operated by the agency, or by a private organization on behalf of the agency, were audited during the first two years of the current audit cycle? (N/A if this is **not** the *third* year of the current audit cycle.) ☒ Yes ☐ No ☐ NA

115.401 (h)

- Did the auditor have access to, and the ability to observe, all areas of the audited facility? ☒ Yes ☐ No

115.401 (i)

- Was the auditor permitted to request and receive copies of any relevant documents (including electronically stored information)? ☒ Yes ☐ No

115.401 (m)

- Was the auditor permitted to conduct private interviews with residents? ☒ Yes ☐ No

115.401 (n)

- Were residents permitted to send confidential information or correspondence to the auditor in the same manner as if they were communicating with legal counsel? ☒ Yes ☐ No

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

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

The following evidence was analyzed in making compliance determination:

1. Documents:
    a. Annual Report
    b. Website
2. Interviews:
    a. PREA coordinator

Findings (By Provision):

115.401 (a). Woodward Academy. website contains the results of all the PREA audits conducted. Such information can be found at Woodward_PREA_Report_2018.pdf (wwacademy.com).

115.401 (b). The Woodward Academy facility is the one of several facilities operated by the governing agency.

115.401 (h). During the inspection of the physical plant the auditor and was escorted throughout the facility by the director. The auditor was provided unfettered access throughout the institution. Specifically, the auditor was not barred or deterred entry to any areas. The auditor had the ability to freely observe, with entry provided to all areas without prohibition. Based on review of documentation the facility is compliant with the intent of the provision.

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

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

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

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

Corrective Action:

No corrective action is recommended for this standard.

Standard 115.403: Audit contents and findings

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

115.403 (f)

- The agency has published on its agency website, if it has one, or has otherwise made publicly available, all Final Audit Reports. The review period is for prior audits completed during the past three years PRECEDING THIS AGENCY AUDIT. The pendency of any agency appeal pursuant to 28 C.F.R. § 115.405 does not excuse noncompliance with this provision. (N/A if there have been no Final Audit Reports issued in the past three years, or in the case of single facility agencies that there has never been a Final Audit Report issued.) ☒ Yes ☐ No ☐ NA

Auditor Overall Compliance Determination

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

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

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

Instructions for Overall Compliance Determination Narrative

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

1. Documents:
    a. Review of facility and agency web-stie.

Findings (By Provision):
115.403 (f). Woodward Academy will store all of their PREA Audit reports under their website. Once received Woodward Academy will readily make all final audit reports available to the public. It should be noted that during the course of the audit phase the facility umbrella agency changed to Vivant Behavioral Healthcare. The previous Woodward Academy report can be found at: Woodward_PREA_Report_2018.pdf (wwacademy.com).

Corrective Action:
No corrective action is recommended for this standard**.**

AUDITOR CERTIFICATION

I certify that:

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

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

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

Auditor Instructions:

Type your full name in the text box below for Auditor Signature. This will function as your official electronic signature. Auditors must deliver their final report to the PREA Resource Center as a searchable PDF format to ensure accessibility to people with disabilities. Save this report document into a PDF format prior to submission.[1] Auditors are not permitted to submit audit reports that have been scanned.[2] See the PREA Auditor Handbook for a full discussion of audit report formatting requirements.

Latera M. Davis May 16, 2022

Auditor Signature **Date**

[1] See additional instructions here: https://support.office.com/en-us/article/Save-or-convert-to-PDF-d85416c5-7d77-4fd6-a216-6f4bf7c7c110 .

[2] See *PREA Auditor Handbook*, Version 1.0, August 2017; Pages 68-69.